HOSPITAL ABSTRACTS

A MONTHLY SURVEY OF WORLD LITERATURE

PREPARED BY THE DEPARTMENT OF HEALTH

AND SOCIAL SECURITY

VOLUME 19, NO. 9, ABSTRACTS 1239-1398. SEPTEMBER 1979

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HOSPITAL ABSTRACTS

Vol. 19 September, 1979 No. 9

HOSPITALS IN GREAT BRITAIN

See also Abstract Nos. 1334, 1358, 1384

1239. BOLTON, J. **The development of the hospital and some current concepts.** *Hospital Engineering*, London, 1979, May, vol. 33, no. 4, pp. 6-11.

The history of hospital design, with particular reference to Great Britain, is traced. Present problems are enormous and are associated with the planning of services, the building of new hospitals, and the maintenance of existing stock. The need for standardization is now accepted. Because of rapid changes in medical science, speed of planning and construction coupled with a flexible solution are the key requirements. Research and development have been devoted to trying out and either rejecting or developing ideas which have emerged. Possible future work is outlined with particular reference to the co-ordination of engineering services and the use of computers in design.

HOSPITALS IN OTHER COUNTRIES

1240. MEADE, J. A. **Some present problems of N.Z. public hospital service.** *New Zealand Hospital*, Wellington, 1979, Jan./Feb., vol. 31, no. 1, pp. 8-9, 11-12.

Surveys have shown that there is a shortage of medical manpower in New Zealand, within both the Department of Health and the hospital system. Most of the medical superintendents of the larger New Zealand hospitals reached their position via a clinical career and most are still clinically involved. This situation has proved satisfactory. However, able clinical administrators receive little reward for their extra responsibilities and have tended to stay in smaller centres. As for senior medical staff, it is difficult to attract good specialist staff to small centres. Physicians are encouraged to work as specialists, but not in too narrow a field. They also provide a programme of postgraduate education for their junior colleagues, at least in the larger hospitals. The number of doctors in New Zealand will have increased substantially by the end of the century; New Zealand graduates are already filling most of the junior hospital posts and administrators must make time available for them to pursue specialist studies. The junior doctor should be aware of his legal responsibilities with regard to answering emergencies.

1241. MITCHEL, M., editor. **A practical guide to long term care and health services administration.** Revised edition. Greenvale, N.Y., Panel Publishers, 1978, xi, 364pp. $30.00

In this revised edition increased emphasis is placed on administrative theory and practice in long-term care. The 20 chapters written by practitioners in the health service field present various views and philosophies and provide an indication of the changing nature of long-term care in the United States. Aspects considered include: administration; organization; functional programming; change; personnel management; role of

the administrator; legal aspects; rehabilitation in geriatric nursing; role of social work; psychiatry of ageing; pastoral care; nutrition services; and a historical view of the influence of Medicare and Medicaid on nursing homes.

1242. BLAIR, B. J. **Air force hospital expands physical facility and mechanical systems.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 187-188, 190.

The 1,000-bed Wilford Hall Medical Center, Lackland Air Force Base, Texas, is the Air Force's largest and most sophisticated medical facility. This paper describes a phased construction, addition/alteration project scheduled for completion in 1982. While not increasing the bed capacity, the work will increase the hospital's space from 481,000 square feet to 1,250,000 square feet, modernize all facilities and systems and provide a total energy plant.

PLANNING, DESIGN AND CONSTRUCTION

See also Abstract Nos. 1252, 1253

1243. EDGE, D. R. **A hospital must study cost, codes, alternatives to decide on reuse or new building.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 109, 110, 114, 118, 120, 122.

Nine times out of 10, it is more economical to re-use an old building than to replace it, assuming that the building is structurally sound. However, to cope with the impact of regulatory codes, design, and attitudes in a renovation project, a hospital may have to make compromises and consider many alternatives to its plan. The most important step to ensure a successful renovation project is to obtain the services of the best and most knowledgeable architects and other advisers.

1244. PARKER, W. **Flexible designs are key to reuse projects.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 125-126, 130, 132, 134.

Re-use, renovation, or remodelling projects are going on continuously in most health care facilities and are likely to increase. Traditional planning to meet this situation has been the preparation of a facility master plan, but this cannot meet the rate of change in health care delivery and the resulting dynamic needs for facilities. Instead strategic facility planning can be used. It involves three interrelated variables: planning, the design and the programme. New and more flexible design alternatives result from the use of this model. There is also a need for more explicit criteria with which to evaluate potential planning/programme/design options; possible criteria are presented in two tables.

1245. SPRAGUE, J. G. **Is recycling of buildings a healthy alternative for the hospital industry?** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 82-84.

Changing methods of health care delivery, health care costs, building costs, and other external factors are forcing hospitals to consider re-using, re-fitting and reconfiguration of existing facilities as alternatives to new construction. This paper discusses the viability of this trend, its long-term value, and what is involved in determining the feasibility of re-using or recycling existing facilities. Although re-use can be justified socially and economically, mechanisms are needed to provide the incentive for re-use projects.

1246. HASELHUHN, G. R. and GRAPSKI, L. **Rebuilding for the future: a forward-looking master plan.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 167-168, 171, 172.

The history of Allegheny General Hospital, Pittsburgh and its current rebuilding project are outlined to demonstrate the reasons for deciding on rebuilding rather than renovation of the existing building. The replacement building will be built around the existing hospital so that patient services will not be interrupted and little or no revenue will be lost during reconstruction. Replacement is being undertaken in 10 stages: (i) underground utilities; (ii) parking; (iii) new 14-storey hospital; (iv)-(vi) relocation of various departments, demolition of the old hospital, and vertical expansion of the north-west wing; and (vii)-(x) the long-range plan—a new south pavilion, landscaping and street improvements.

1247. DANSK SYGEHUS INSTITUT. Sygehusplanlaegning 1: vurdering af sygehus-planlaegningens tilrettelaeggelse. **[Hospital planning I: evaluation of the hospital planning system.]** (Prokejtrapport 79.01) København, Dansk Sygehus Institut, 1979, 128pp. Kr.35

A series of reports is being issued by the Danish Hospital Institute as a result of a transfer of responsibility for hospital planning to municipal and district authorities. Experience has shown that the increase of local responsibility has not resulted in a coherent planning procedure. This report is from a group set up to make a detailed analysis of local hospital plans in preparation for the establishment of a general planning model.

1248. TUSLER, W. **Could two-level process eliminate costly planning problems?** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 85-90.

Certificate-of-need review is a major thrust in the United States government's programme to contain health care costs. However, lack of concurrent review and incompatibility with cost containment objectives are serious problems, with the present approval process. A possible alternative is suggested. This divides the process into two phases: (i) a conditional approval, directed towards determination of community-wide needs and the organization of services to meet them; and (ii) consideration of more detailed information, similar to the plans required for the present process.

1249. LEVITAN, M. S. **To reuse or reconstruct: that is the question.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 93, 95, 98, 102.

With cost containment being a vital concern, health care facilities must carefully assess differences between the cost of new construction and of renovation. Assuming that all non-financial factors are roughly equivalent, the hospital must decide whether it is less expensive to construct a new facility or to re-use or renovate existing space. To determine financial feasibility the categories of costs involved in renovation and new construction should be examined. One analysis suggests that the potential construction savings of renovation are $18 per square foot and 9.0 per cent of total project costs.

1250. VALLAN, F. D'A. Ospedali più umani: riflessioni sull' architettura ospedaliera. **[More humanized hospitals.]** *Tecnica Ospedaliera*, Milano, 1979, Feb., vol. 9, no. 2, pp. 24-28.

The modern hospital is usually planned on the basis of the concept of the patient as the object of treatment and the staff as units whose productivity is to be increased. This 'standard' hospital reflects an industrial culture and is out of place in countries which do not have a culture of this type. Recognition of the inappropriateness of the large impersonal hospital has led some architects to attempt to relate hospital design to the specific environment. Examples of this are Le Corbusier's design for a hospital in Venice, a design for a hospital in Iran where the technical floors resemble an Eastern bazaar, African 'village' hospitals, and some children's hospitals.

DESIGN OF INDIVIDUAL GENERAL HOSPITALS

See also Abstract No. 1246

1251. BUILDING DESIGN PARTNERSHIP. **Research study: interstitial space; a report on the provision of interstitial space in the form of interfloor service voids in the design of the teaching hospitals at Leeds and Nottingham; including a comparison with an alternative approach as used in the medical school and dental hospital at Leeds; a comparative assessment of costs; a functional appraisal of the buildings now in use; and a concluding summary.** Preston, Building Design Partnership, 1978, [ii], 79pp.

This report is concerned primarily with the provision of space within buildings for the installation and distribution of services. It considers the reasoning which led to an interstitial space design approach for the Nottingham and Leeds Teaching Hospitals. The study is in six sections: (i) introduction, building form and the interstitial floor space; (ii) building facts, drawings and illustrations taken from the Leeds and Nottingham Teaching Hospitals; (iii) a comparison of the Leeds Medical School and Dental Hospital with the Leeds Teaching Hospital; (iv) comparative costs; (v) changes to original proposals made during design, construction and occupation; and (vi) recommendations and conclusions.

1252. DENYSE, R. A. **Hospitals meet space and HSA criteria through merger.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 137-138, 142, 145.

Following the merger of the St. Francis Hospital and St. George Hospital, Cincinnati, Ohio, a professional hospital planning firm was employed to consider three alternatives: (i) an addition to St. George Hospital (then 10 years old); (ii) the complete renovation of St. Francis Hospital (then 90 years old); (iii) the construction of a new hospital on a new site. The study disclosed that the age of St. Francis Hospital and the fact that it was constructed of heavy timber ruled out its expansion. The original construction of St. George Hospital permitted vertical expansion of only two storeys, which would be inadequate by 1990. It was also estimated that the cost of a new hospital would be less than that of reconstruction. An application for certificate-of-need approval was prepared and after discussions with the Health Systems Agency approval for a new 240-bed hospital on a new site was obtained and preliminary construction work began on 7 November 1978.

1253. ALLEN, R. W. **Renovation saves hospital landmark.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 175-176, 178.

Designed in a Spanish colonial style in 1922, Long Beach (Calif.) Community Hospital originally had 125 beds, but a 1959 addition brought it up to its present 300-bed capacity. This paper describes how the building has been strengthened to meet earthquake safety requirements, restored and relandscaped without destroying its traditional and unusual characteristics and with minimum interruptions of services.

1254. INGOLIC, P. Der Ausbau des LKH Leoben. **[New buildings for Leoben Hospital.]** *Österreichische Krankenhaus-Zeitung*, Vienna, 1979, vol. 20, no. 3, pp. 141-144, 146-148.

The first stage of the new 810-bed Leoben Hospital was officially opened in September 1978. It has five sections: (i) seven-storey ward block, with pharmacy, administration, pathology departments, kitchens, laundry, chapel, etc.; (ii) living accommodation for staff and nurses' home; (iii) conversion of existing building for the women's and ear nose and throat departments; (iv) and (v) centralized out-patient department and conversion of the existing building to house temporary examination and treatment departments. The 32-bedded wards are on a double corridor plan with three six-bedded, three three-bedded, two two-bedded and one single patients' rooms. Intensive care units (medical, six-bedded, and surgical, nine-bedded) are on the first floor. The second and final stage will provide a diagnosis and treatment block. Existing buildings on the site have been demolished as construction proceeded.

1255. ASHLEY, I. E. and MANN, G. J. **Abandoned air force base redesigned as rehabilitation center.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 181-182, 184.

The New Mexico Rehabilitation Center, Roswell, opened on June 10 on the site of a former United States Air Force base. The inadequate and scattered nature of the buildings led to the preparation of a master plan for renovation and development. The first phase, completed in October 1978, provided a vocational centre in four single-storey buildings surrounding the original hospital but separated from it by several courtyards. There were also minor changes to the original building. Subject to the availability of funds, phase two will include new nursing units, physical and occupational therapy units, recreational areas, and housing. The design concepts of the project are listed. A site plan and four photographs are included.

EXTENSIONS AND RECONSTRUCTIONS

See also Abstract No. 1243

1256. KENSINGTON AND CHELSEA AND WESTMINSTER AREA HEALTH AUTHORITY (TEACHING). **St. Mary's Hospital and Medical School redevelopment of the North West District: first phase feasibility study.** London, Kensington and Chelsea and Westminster Area Health Authority, 1978, [iv], 130pp.

This feasibility study considered the extension of one of the hospital blocks to take 300 acute surgical beds and eight theatres, thereby making the new block of sufficient

size to represent all estimated 1986 District needs for surgical accommodation at Praed Street, London. The study is in 11 sections and presents: recommendations; the background to the study; district health care requirements in 1986; the content of Phase I; the site; architect's study; preferred site option; costs; programme for Phase I; later phases; and increased surgical facilities in Phase I. Seven appendices are included which consider: the membership of the Steering Committee and Study Group; population change in 1961-1986; bed usage 1977 and 1986; comparison of beds planned against University of London requirements; detailed capital costs; informal consultation document; and the architects' drawings.

1257. BERG, N. H. **Medical center applies financial strategies to renovation project.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 147-148, 150, 152, 211.

In response to growing concern about the long-term viability of the physical plant of the University of Chicago Hospitals and Clinics, a feasibility study of options for improving in-patient facilities was undertaken. Over 100 individuals were involved in the committees and task forces established. This paper concerns the task force on physical and financial feasibility which was asked specifically to determine the physical and financial implications of two options: continuing on the current course of development; and replacing the facility. The facility was divided into five zones for evaluating the options: in-patient care; ambulatory care; parking; hospital/medical school management; and education and research. Advantages and disadvantages of each option are outlined. Analysis of costs revealed that the replacement option would involve lower costs, both capital and maintenance. Additionally it minimizes the interruption of current operations. It was therefore recommended.

DESIGN OF SPECIAL DEPARTMENTS

See Abstract No. 1311

DESIGN OF SPECIAL HOSPITALS OR UNITS

See Abstract Nos. 1255, 1335, 1367, 1369, 1397

GARDENS AND GROUNDS, PARKING

1258. ANDREW, R. and HARRIS, M. **Room in the waiting room but not in the car park.** *Health and Social Service Journal*, London, 1979, May 11, vol. 89, no. 4641, pp. 562-563.

Internal road layouts and car parking facilities are totally inadequate at the majority of hospitals. In general, short-stay hospitals attract more traffic than long-stay ones due to a higher staff/bed ratio and a larger number of visitors per patient. The size of the out-patient department also influences parking demand. Often hospitals with very limited land restrict vehicles to essential categories of hospital users. At old, spread out hospitals, indiscriminate parking causes serious access problems and may be a potential fire hazard. These problems increase administrative costs and use up staff time. Simple measures for effective traffic management include: (i) defined parking areas; (ii) a

parking allocation system; (iii) one-way operation of access roads and exits; (iv) improved signposting; and (v) attempts to improve the provision of local public transport.

ENGINEERING SERVICES

ARTIFICIAL LIGHTING

1259. HAINAULT, M. L'éclairage en salle d'opération. 3e partie. **[Lighting in the operating theatre. Part 3.]** *Techniques Hospitalières*, Paris, 1979, April, vol. 34, no. 403, pp. 52, 57-66.

Short sections on theatre lighting describe: (i) the properties required in lighting equipment in regard to shadows, visual fatigue, dazzling, contrast, heat output, reproduction of colours, and mechanical design (with particular reference to ease of movement); (ii) the recommendations of the French Lighting Association; (iii) recommendations of the Illuminating Engineering Society; (iv) satellite lighting equipment; (v) apparatus for and methods of measuring various characteristics of lamps, and (vi) illustrated descriptions of seven recent light domes.

TRANSPORT IN GENERAL

See Abstract No. 1356

HEATING

See also Abstract No. 1261

1260. HIERGEIST, A. Bau-und betriebstechnische Einflussfaktoren auf den Energieverbrauch von Krankenhäusern und Vorschläge zur Kostenreduzierung. **[The influence of constructional and management factors on energy consumption in hospitals and proposals for cost reduction.]** *Österreichische Krankenhaus-Zeitung*, Vienna, 1979, vol. 20, no. 3, pp. 151-152, 154, 156, 158, 161-168, 171-172.

This is a detailed study, with 96 references to the literature, which aims to set out the specific constructional and management factors which influence energy requirements in a general hospital. The subject is dealt with under the following heads: the effects of technical building factors on energy consumption; the effect of physical factors on energy consumption; and the effect of installations and technical management on heat and cold requirements and on the consumption of electricity.

VENTILATION AND AIR CONDITIONING

1261. BECK, K. Wärmerückgewinnung bei raumlufttechnischen Anlagen in Krankenhäusern. **[Heat recovery from ventilating installations in hospitals.]** *Krankenhaus*, Stuttgart, 1978, Nov., vol. 70, no. 11, pp. 420-426.

There are a number of solutions to the problem of heat recovery in ventilating

installations. For hospitals the most important apparatus is that with contact surfaces or with partition surfaces. The continuous running of hospital installations make heat recovery particularly productive and economic. Since energy costs are bound to rise every opportunity to save energy must be used. This paper illustrates the possibilities with three typical examples of heat recovery and discusses their suitability for hospitals.

MAINTENANCE OF BUILDINGS AND EQUIPMENT

See also Abstract No. 1266

1262. CARA, M. and BROUARD, S. Fiabilité et maintenance: cas des appareils de ranimation. **[Reliability and maintenance: with reference to resuscitation equipment.]** *Techniques Hospitalières*, Paris, 1979, March, vol. 34, no. 402, pp. 41-50.

The need for reliable resuscitation equipment in the hospital cannot be overemphasized. The authors present a theory of reliability and a series of mathematical calculations and graphs illustrating mean time between failures, reliability when the number of failures is constant, the effect on failure rate of regular maintenance, the useful life of items of equipment, and the incidence of running-in failures. They suggest that preventive maintenance, i.e. the replacement of parts before they fail, is safer and less costly in the long run than repairs after failure. They would like manufacturers of hospital equipment to give details of mean time between failures, useful life, and repair time in their advertising literature.

1263. TANVERDI, C. and CLEMONS, W. L. **Management information system ensures maintenance coordination.** *Hospitals*, Chicago, 1979, Jan. 1, vol. 53, no. 1, pp. 79-81.

At Massachusetts General Hospital, the 200 maintenance staff care for two million square feet of space and perform all of the usual maintenance functions for 16 patient-care and nine support buildings; in addition they are responsible for a wide range of technically complex construction and renovation projects. The limited amount of information available for decision-making for these tasks led to the development of the computerized management information system described in this paper. The dual-mode data entry system uses mark-sense forms for the majority of input data and keypunched cards for the remainder. The system produces separate daily reports for each of the eight workshops. The system provides accurate, up-to-date information that managers can use to make decisions concerning allocation of manpower, staff performance, and use of resources.

PIPING INSTALLATIONS

See Abstract No. 1313

SANITARY EQUIPMENT AND FITTINGS

1264. **Shower trolley could mean big changes in hospital bathing procedures.** *New Zealand Hospital*, Wellington, 1979, Jan./Feb., vol. 31, no. 1, p. 15.

A New Zealand firm has designed a new style shower trolley. One foot pedal raises

and lowers the trolley from a convenient working height to wheelchair height, while a second raises and lowers the central platform, providing a padded surface, and lowering the foot end so that water drains away through a hose. All the plumbing needed is a drain in the floor and a controllable flow of water suitable for a hand-held spray. Drainage is so efficient that patients can also be dried and dressed on the trolley. This simple trolley has the following advantages: (i) patient comfort; (ii) reduced risk of back injury to nurses; (iii) reduced bathing time; (iv) easy cleaning; and (v) the small amount of water used.

EQUIPMENT, FITTINGS, FURNITURE

FLOORS AND FLOOR COVERINGS

1265. **Wool's contribution to the hospital environment.** *New Zealand Hospital*, Wellington, 1979, Jan./Feb., vol. 31, no. 1, pp. 16, 18.

Carpet installation in hospitals using New Zealand wool is becoming a major trend both in New Zealand and overseas. Studies carried out by the Wool Research Organisation of New Zealand and the International Wool Secretariat have shown that wool carpet is generally cheaper than hard floors when maintenance and cleaning are taken into account. Carpeted areas showed no increase in the numbers of bacteria or pathogens, and most stains could be avoided if the carpet was mopped quickly. The problem of pushing trolleys can be solved by increasing the diameter of the wheels. In addition carpeting reduces noise and humidity and lessens the risk of falls. Wool carpets and soft furnishings do not ignite easily. Wool blankets have also been found not to harbour bacteria and are now able to meet hospital laundering requirements. The New Zealand Wool Board offers a textiles consultancy service for carpets and a number of other products.

EQUIPMENT GENERALLY

See Abstract No. 1262

MEDICAL EQUIPMENT

1266. HOPPS, J. A. **Biomedical equipment maintenance in Canadian hospitals.** *Journal of Medical Engineering and Technology*, London, 1979, March, vol. 3, no. 2, pp. 63-65.

A questionnaire on the management of electromedical equipment was prepared and sent to 100 hospitals throughout Canada. This paper gives a brief description of the questionnaire and a résumé of the replies received, with particular reference to radiology, biomedical engineering, equipment maintenance services, patient safety procedures, equipment evaluation, and preventive maintenance. Despite inadequacies highlighted by the replies, it appears that most Canadian hospitals are coping with the problem of equipment maintenance and care. There is less cause for complacency with regard to the safety of equipment and procedures.

ELECTRONIC EQUIPMENT

See Abstract No. 1347

TROLLEYS, STRETCHERS, ETC.

See Abstract No. 1264

STAFF GENERALLY

STAFF COMPLEMENTS

See Abstract Nos. 1277, 1338, 1370

RECRUITMENT AND MANPOWER

See Abstract Nos. 1270, 1364

STAFF MANAGEMENT

See Abstract No. 1271

STAFF TRAINING

See Abstract Nos. 1269, 1272, 1276, 1281, 1283, 1351

STAFF WELFARE

See Abstract Nos. 1273, 1274, 1343

OTHER STAFF AMENITIES

1267. LASSERRE, J.-M. Que pensent-ils de leur journal d'hôpital? **[What do they think about their hospital newspaper?]** *Techniques Hospitalières*, Paris, 1979, March, vol. 34, no. 402, pp. 77-80.

Questionnaires completed by between one and 14.2 per cent of the staff in eight regional hospitals in France showed that the large majority of these responders felt that there was a need for regular information on the day-to-day life of the hospital in which they worked. Approximately 40 per cent felt that the hospital newspaper met their information requirements in this respect, while 50 per cent considered that there was scope for improvement, and 30 per cent thought that additional means of information should also be used. The most popular articles in hospital newspapers were on practical questions or training, followed by in-depth articles on administrative or medical topics. Some readers expressed a wish for a readers' forum and articles on foreign hospitals.

SPECIAL CLASSES OF STAFF

MEDICAL STAFF

See also Abstract Nos. 1297, 1338, 1370

1268. HYDE, A. **Juniors at the sharp end.** *Health and Social Service Journal*, London, 1979, May 18, vol. 89, no. 4642, pp. 596-597.

The author spent a long shift (Friday to Monday morning) with a young surgical house officer at the Royal Hampshire County Hospital, Winchester, to see the work and strain involved. The day began at 9 a.m. with three hours in the theatre and from midday the doctor was attending casualty patients who might need surgery. In the afternoon she completed a check on patients admitted from casualty and on those who had returned from surgery. In the evening she returned to the theatre but was frequently called away to emergencies and was subsequently called five times during the night. The doctor admitted that the strain affects her attitude to nurses and patients and she resented the low level of on-call payments. However, she seemed to accept many of the disadvantages of hospital life and was not particularly interested in junior doctor politics.

1269. GIFFORD, J. F., editor. **Undergraduate medical education and the elective system: experience with the Duke curriculum, 1966-75.** Durham, N.C., Duke University Press, 1978, xiv, 243pp. $9.75

In response to demand for changes in the existing courses in medical education Duke University School of Medicine, Durham, North Carolina, established in the 1960's a new model of medical education. In the first year the core of principles and information considered essential for any physician were presented by each basic science department. In the second year students entered the wards of medicine, surgery, obstetrics and gynaecology, paediatrics and psychiatry. The third and fourth years were devoted to elective courses chosen in accordance with the students' career aims. The first 10 years of experience with this model are discussed, the historical background and circumstances unique to Duke University outlined, and the overall educational pattern evaluated.

NURSING STAFF

See also Abstract Nos. 1328, 1330, 1331, 1385

1270. STEWART, W. **Nurse allocation handbook.** (KFC 78/266) London, King Edward's Hospital Fund for London, 1979, [iv], 38pp. £1.00

This handbook brings together many of the General Nursing Council's references which have implications for allocation officers. It is in four sections which consider: student and pupil allocation and training; aspects of general nursing; psychiatric nursing; and mental subnormality nursing. A chronological list of the circulars quoted is included.

1271. ADKINS, R. D. **Responsibility and authority must match in nursing management.** *Hospitals*, Chicago, 1979, Feb. 1, vol. 53, no. 3, pp. 69-71.

In recent years, a wide variety of nursing management systems have been developed; the majority have, at best, realized only marginal successes. At St. Mary's Hospital, Galesburg, Ill., a new management structure has been developed. The main feature is that, at each level of management, the person charged with responsibility has the authority necessary to ensure that the work is carried out. This approach has helped to ensure that nurse managers can fulfill their responsibilities, has changed the roles of nurse managers at all levels throughout the structure, and has provided a system that is highly responsive to operational and staff problems and concerns.

1272. GENERAL NURSING COUNCIL FOR ENGLAND AND WALES. **Training syllabus, register of nurses: general nursing.** London, General Nursing Council for England and Wales, 1977, 13pp. £0.40

This syllabus sets out in broad terms the subjects to be studied during training for Registration in the general part of the Register maintained by the General Nursing Council for England and Wales. The concept underlying the syllabus is that of total patient care: nursing; the study of the individual; and the nature and cause of disease together with its prevention and treatment. The sections consider: the principles and practice of nursing, including: first aid; study of man and his environment; the nature and causes of ill-health; and practical experiences required for the training of nurses for admission to the general part of the register.

1273. ERIKSEN, K. and GOLDSCHMIDT, A. Undervisning og träning holder ryggen skadefri. **[Instruction and training prevents back injuries.]** *Sygeplejersken*, København, 1979, May 9, no. 18, pp. 12-14.

The average number of days spent off work as a result of each accident caused to staff by overstrain is 25.3, 44 per cent of all strain accidents causing up to a week off work, 31 per cent from eight to 21 days, and one in eight even longer. Training of all staff categories must involve a large number of lessons in the techniques of lifting and carrying, and provision for many hours in the gym throughout the course. Training must include practical instruction in working movements and lifting technique on the wards, as has been practised by Mensendieck instructors at Bispebjerg Hospital since the middle 1960s. Instruction must also be given in the correct use of mechanical aids, so that users are competent and confident in their application; and staff must also be made familiar with the many different kinds of bed. This should result in a reduction in the frequency and seriousness of strain injuries to staff.

1274. SCHMIDT, E. Arbejdsteknik i patientplejen: korrekt arbejdsteknik skal väre indarbejdet hos alle medarbejdere. **[Correct working techniques must be used by all those involved in patient care.]** *Sygeplejersken*, København, 1979, May 9, no. 18, pp. 4-5, 21.

Staff who are to work with beds or other apparatus must be consulted during trials and prior to purchase, and must be properly trained in their use. Both new and experienced staff require thorough training in methods of working. Discussions the author, a physiotherapist, has had with nursing staff show that there are certain lifting

tasks which are particularly difficult to perform. The prime causes of back trouble are: lifting a seriously ill patient higher up in bed; raising the head end of a bed without the patient's help; lifting a patient out of a chair; and holding a patient on his side—particularly where a water mattress is used. The general rules to avoid strain for all lifting tasks are described. Physiotherapists are trained to teach staff special methods, and should be asked to do so. The article is illustrated with eight instructional photographs.

1275. WHELTON, B. J. **An operationalization of Martha Roger's theory throughout the nursing process.** *International Journal of Nursing Studies*, Oxford, 1979, vol. 16, no. 1, pp. 7-20.

The purpose of this paper is to integrate the Martha Rogers theory of nursing with the nursing process to provide a framework for nursing practice. The framework of her theory provides: (i) a way of looking at the patient as an individual; (ii) a focus for nursing intervention; and (iii) a basis for predicting outcomes. The system links the physical ills of the patient with the effect these ills may have on his social and environmental relationships and activities. The next stage is an assessment by the nurse followed by a nursing diagnosis of the patient, which is in turn related to the nursing care plan. Evaluation of care may change as treatment begins to show results, and the goal is to return the patient to the best possible state of health. A detailed study in tabular form shows the application of the theory in two different clinical situations.

1276. SLATER, C. H., editor. **The education and roles of nursing service administrators: a collection of papers from three conferences.** Battle Creek, Mich., W. K. Kellogg Foundation, 1978, 103pp.

This is a collection of papers from three conferences, largely based on North American experience. The first section consists of four papers on the theme of 'Nursing service administration today'; the second section consists of six papers on the subject of 'Educational models for nursing and health administration'. The increased emphasis on administration is making interdisciplinary education necessary. Clinical capabilities are not always an indication of the ability to handle budgeting or difficult negotiations. The solution put forward is a programme of training specifically for nursing and health service administration.

1277. RHYS HEARN, C. **Comparison of Rhys Hearn method of determining nursing staff requirements with the Aberdeen formula.** *International Journal of Nursing Studies*, Oxford, 1979, vol. 16, no. 1, pp. 95-103.

This paper presents a comparison between the nursing workload calculations made during the trials of the Rhys Hearn method and similar calculations using the Aberdeen formula. The Rhys Hearn method is based on 'ideal care' as seen by nurses in charge of wards, while the Aberdeen method is based on observing care over a large number of wards. The comparison between the two sets of records is designed to show the relation between the workloads of the five dependency categories as used in the Aberdeen formula and as calculated from the Rhys Hearn studies. The proportions of workload assigned to different categories of staff are compared, and finally, a breakdown is made of how the equivalent of the Aberdeen dependency factors in the Rhys Hearn method vary between 'minimum' and 'optimum' standards of care. The comparison showed a

marked difference between the two systems arising from changes in policy for nursing geriatric patients and differences in standards of care. In the Rhys Hearn studies, where standards are defined and care monitored for individual patients rather than for care groups, the standard of care could determine workloads, and thereby staff numbers, more consistently than with the Aberdeen formula.

1278. HUNGLER, B. P. and others. **Professionalism in nursing master's graduates.** *Journal of Advanced Nursing*, Oxford, 1979, March, vol. 4, no. 2, pp. 193-203.

The majority of nurses in the United States currently seeking advanced preparation choose clinical specialization as the functional area rather than teaching as in the past. Although this change has been well documented, few scientific investigations have been conducted on the graduates from master's programmes, most of them concentrating on the personal characteristics of students. This study investigated the relationship between a nurse's area of functional preparation in a master's degree programme and her level of professionalism. The criteria for professionalism were: enrolment in a formal programme of study; subscription to professional journals; attendance at non-formal education programmes; number of papers published; membership of professional organizations; and employed in prepared area. Questionnaires were sent to 637 graduates; of 395 returned, only 272 were usable. Postgraduates prepared as teachers met the criteria for professionalism more often than did postgraduates prepared as clinical specialists.

1279. TOWELL, D. **A 'social systems' approach to research and change in nursing care.** *International Journal of Nursing Studies*, Oxford, 1979, vol. 16, no. 1, pp. 111-121.

The author suggests that a 'special systems' approach to nursing research provides a means of linking research with the problem of change in nursing care. Most research work which has used the 'social systems' approach has involved not only conducting research on health care issues but also helping to implement change. Examples are described of the application of this type of research to three different health care systems: (i) psychiatric hospitals; (ii) residential institutions for the disabled; and (iii) geriatric hospitals. It appears that attempts to change nursing practices in order to improve care can be influenced by a number of contributory factors, such as hospital organization and nurse training. Attempts to change the nurse's role in relationship to patients can only be brought about if account is taken of a wider pattern of management, both within the hospital and the health care system as a whole. Staff should be given opportunities to examine existing practices and draw on the experience of others so that they will be motivated to promote change where it is needed.

1280. HODGMAN, E. C. **Closing the gap between research and practice: changing the answers to the 'who', the 'where' and the 'how' of nursing research.** *International Journal of Nursing Studies*, Oxford, 1979, vol. 16, no. 1, pp. 105-110.

The author believes that matters relating to the 'who', 'where' and 'how' of nursing research have obstructed the development of a relationship between nursing research and nursing practice. Researchers often receive their training in disciplines not directly related to nursing practice. The clinical setting rather than the university is the most suitable background for nursing research, but because it is less controllable, many

researchers leave for quieter settings and the link between research and practice becomes increasingly remote. However, there is evidence that nursing research in the United States is moving more into the work setting, helped financially by the Nursing Grants Section of the Division of Nursing. Two factors in the clinical setting itself are also bringing changes; (i) a return to a more personal relationship between nurse and patient; and (ii) the fostering of research by nursing service administrators within their own institutions.

1281. JONES, J. W. **United States undergraduate nursing education: a system pathology.** *International Journal of Nursing Studies*, Oxford, 1979, vol. 16, no. 1, pp. 123-133.

There is a good deal of concern in the United States about the difficulties encountered by nursing graduates when making the transition from student to professional nurse. This paper describes a study to discover whether the problem is caused by the nursing educational system. A system dynamics computer simulation model of United States under-graduate courses in nursing education was used and the operation of the model is described. The behaviour of each of 20 nursing schools was simulated over a 25 year time frame from 1965 to 1990. The characteristics of all the schools were quite similar in terms of growth, staffing, and levels of achievement. Often numbers of students grew too large for the available teaching facilities, resulting in graduates who were lacking in some aspect of experience. A simulation model such as the one described can be helpful in finding out deficiencies in nursing education courses and providing a guide for future course planning.

ORGANIZATION AND ADMINISTRATION

See also Abstract Nos. 1240, 1241, 1252, 1271, 1276, 1366, 1375, 1376

1282. BENNETT, A. C. **Systems approach is needed for data processing function.** *Hospitals*, Chicago, 1979, Feb. 1, vol. 53, no. 3, pp. 48-51.

Computers have the capability of providing a picture of the whole organization if used properly and with creativity. The administrator who seeks to improve and strengthen information processing in his hospital needs to answer six questions: (i) what is the state-of-the-art of communication within the hospital; (ii) what exactly are the characteristics and qualities of the planning and control processes used in the hospital to ensure that its needs are being met effectively and efficiently; (iii) with respect to the hospital's computer effort, how does management view and exercise management roles and relationships within the total organizational environment; (iv) to what extent has top administration placed responsibility for information systems with departmental managers; (v) what are the present capabilities of managers to manage with information systems; and (vi) how aware is the hospital of external sources of communication systems.

GOVERNING BODIES, COMMITTEES

1283. RICE, K. A. and REID, J. M. **Trustee development comes of age.** *Trustee*, Chicago, 1979, Feb., vol. 32, no. 2, pp. 21-25.

Trustee development as a means of improving the performance of hospital boards is

quickly gaining ground in United States hospitals. The aim of the scheme is to ensure that board members share the responsibility with the administrators for making the board function efficiently. The formation of a committee is a necessary preliminary to putting a development scheme into action and different hospitals use different types of committees. A committee at Northwest Hospital, Seattle, devised a new orientation programme for trustees and thereby put new life into the hospital's by-laws. Small hospitals can accomplish a great deal by combining their efforts. The responsibilities of the committee for board development include: (i) an assessment of the board's educational needs; (ii) developing criteria for selecting new board members; and (iii) ensuring there are adequate funds available for board development schemes. A number of existing seminars and conferences are listed which could form part of a trustee development programme.

ECONOMICS OF HOSPITAL MANAGEMENT

See also Abstract Nos. 1286, 1296, 1350, 1377

1284. CHAPALAIN, M.-T. and MARIELLE, M. B. Vers une nouvelle comptabilité hospitalière? **[Towards a new hospital accounting system?]** *Santé Sécurité Sociale: Statistiques et Commentaires*, Paris, 1979, Jan./Feb., no. 1, pp. 55-60.

A method developed at the Gustave Roussy Cancer Institute at Villejuif, which is aimed at improving the management of hospital resources, is described. Information is collected about the 'target-groups' (the patients and their diseases), the organs or systems affected by cancer, the resources employed, the amount of time during which equipment is used, and the staff time devoted to each patient. This information is currently presented in the form of quarterly ward activity tables consisting of graphs or histograms showing, for example, length of stay related to site of tumour, amount of care in relation to site of tumour and stage of treatment (assessment, surgery, radiotherapy, etc.), average stay in relation to stage of treatment. Whether the amount of care is related to stage of treatment, for example, will be confirmed or disproved when fairly long statistical series have been analyzed. In addition to improving current management of resources, it is hoped that this method may in the future be used for forecasting the development of the hospital and assessing the cost of innovations.

1285. Kostenbeheersing en het handhaven van de kwaliteit van de gezondheidszorg. **[Financial control and the upkeep of health care quality.]** *Ziekenhuis*, Utrecht, 1979, March 21, vol. 9, no. 6, pp. 132-137.

A general practitioner, a radiologist and a professor of hospital sciences express some views on keeping down hospital costs. Patients are becoming more demanding and selection for hospital treatment starts with the general practitioner (at present 15 per cent of his patients). Reduction in the number of hospital beds is suggested by making beds only available for seriously ill patients and putting more emphasis on polyclinical treatment. The financial calculation unit for a hospital should not be the number of beds, but the number of treatments and investigations. These again could be reduced by avoidance of unnecessary routine and duplicated tests which only confirm the same diagnosis. Pressure from industry to buy the latest technological equipment remains a problem. Regarding specialists' fees, the present system of independent

contracts should not be changed to one of salaried appointments. This would encourage development of private clinics with consequent long health service waiting lists. General practitioners, of whom there should be more, have to be strictly selective, which includes considering the effect on the patient of a hospital admission or, even more so, a nursing home admission which can change the patient's whole life. The time has come for less reliance on institutions, and re-education of the patient to provide more self-help at home.

BED OCCUPANCY, ECONOMIC USE OF BEDS

See also Abstract Nos. 1361, 1386

1286. GRIFFITH, J. R. and WELLMAN, B. T. **Forecasting bed needs and recommending facilities plans for community hospitals: a review of past performance.** *Medical Care*, Philadelphia, 1979, March, vol. 17, no. 3, pp. 293-303.

Between 1967 and 1971 six studies were made to forecast the bed requirements of Michigan hospitals, using empirical studies of patient origin and official population forecasts. In 1975 a group began to review the previous studies and to check the forecasts against the actual results. Although the population estimates had proved accurate there had been a considerable overestimation of bed needs. The review estimates that the errors cost the relevant communities $50 per person per year.

OFFICE MANAGEMENT AND METHODS

1287. SCHOENEMAN, P. F. **Investment in mailroom services produces better communications.** *Hospitals*, Chicago, 1979, Jan. 1, vol. 53, no. 1, pp. 85-88.

A survey of mailroom practices at Providence Medical Center, Seattle, revealed deficiencies directly related to a lack of performance standards, adequate working space and supervision. This paper explains how careful planning and management enabled the mailroom to control copying costs and to improve services to patients, physicians and hospital staff. A floor plan of the replanned mailroom service centre at the hospital showing routes of incoming and outgoing mail is reproduced.

ELECTRONIC DATA PROCESSING

See also Abstract Nos. 1263, 1282, 1299, 1339, 1345, 1346, 1349

1288. BIRKNER, W. and SCHÖN, H. Der kybernetische Prozess als Grundlage zur Gestaltung von Krankenhaus-Informations-Systemen. **[The cybernetic process as the basis for structuring a hospital information system.]** *Krankenhaus-Umschau*, Kulmbach, 1979, April, vol. 48, no. 4, pp. 253-257.

Experience in the introduction of an electronic data processing system for hospital information in a group of hospitals in Western Germany has led to the conclusion that the cybernetic process is a good basis for structuring such a system. It has a positive effect on the functioning of an information service. The cybernetic process represents a basis for development and the control technique is of great assistance in the representation of complicated information. It makes simulation possible and thus replaces traditional trial and error methods. Details of the technique are given.

1289. MAHAJAN, V. **Computers in hospitals: an innovation study.** *Technological Forecasting and Social Change*, New York, 1979, Feb., vol. 13, no. 2, pp. 169-186.

The use of computers and information techniques for hospital management is discussed here. The number of hospitals using computers has increased as have the capabilities of computers. A table is given to show the most common reasons for adopting computers; housekeeping functions predominate over clinical applications. Characteristics of hospitals adopting computers are considered and three categories of hospitals shown: innovators; early adapters; and late adapters. Even amongst the innovators the use of computers for clinical applications has not been exploited.

1290. MOL, A. P. M. Automatische informatie—verwerking bij individuele ziekenhuizen. **[Automatic data processing in individual hospitals.]** *Ziekenhuis*, Utrecht, 1979, April 18, vol. 9, no. 8, pp. 194-197.

To make the most economic use of funds available for development of systems in automatic data processing, research was carried out in 13 general and two psychiatric hospitals to find out: (i) whether any system in use would be suitable for study or adoption by other hospitals or co-operating hospital groups; and (ii) whether any individual hospital functions were being automated which were already successfully being developed within larger co-operating groups. It was found that nearly all hospitals used automatic processing systems for finance and administration such as accounts, storage, clinical statistics and patient registration, and improvements were planned using larger computers ('on-line' patient registration). Some hospitals used systems for hospital finance, inventory and purchase and two hospitals operated a system for medical administration. Future development projects were in doubt due to shortage of manpower. A table is given stating for each hospital the functions which are automated, type of computer and state of development. Three hospitals are discussed in more detail because of their successful computer systems and range of automated functions.

1291. INGRUBER, H. Die Daterwerarbeitung im Krankenhaus und das Persönlichkeitsrecht. **[Data processing in the hospital and the rights of the individual.]** *Krankenhaus-Umschau*, Kulmbach, 1979, April, vol. 48, no. 4, pp. 258, 267, 268.

The author discusses the problems which arise when patients' records are stored in computer systems. These include questions of confidentiality as well as other aspects such as the destruction, defacement, misuse and loss of information. The need for legislation to protect patients' records is set out. The earliest legislation in this area in Europe was promulgated in the *Land* of Hessen (1970): the first national legislation was in Sweden (1973); followed by West Germany (1977); France, Denmark and Norway (1978); and Austria (January 1979). Other countries will follow suit shortly.

SECRETARIAL SERVICES

1292. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. **Administrative arrangements: centralised dictating systems.** (Notes on Good Practices 14) London, DHSS, 1979, [6pp]. £0.40

A study was carried out by the Central Management Services Branch of the Depart-

ment of Health and Social Security to provide advice on whether, and in what circumstances, centralized dictating systems can be employed to advantage in the Health Service, and to suggest procedures which will assist in establishing whether those circumstances exist. The study also sought to determine whether particular systems offer significant advantages over others and to formulate advice for determining how levels of need may be assessed. It is recommended that an audio-typing service should be provided by the use of portable dictating machines.

MEDICAL RECORDS

See also Abstract Nos. 1284, 1349

1293. BOYD, N. F. and others. **Observer variation in the classification of information from medical records.** *Journal of Chronic Diseases*, Oxford, 1979, vol. 32, no. 4, pp. 327-332.

The medical records of patients are among the most detailed accounts of clinical experience and should provide a unique source of data for research into the clinical course of disease. To assess the suitability of the record for such research, a study was undertaken to determine if information in patient records could be identified and proved to be valid by a number of observers. Four physicians independently read the same 110 records of patients with Hodgkin's disease. Two physicians used explicit criteria to identify: (i) first symptoms; (ii) systemic symptoms; and (iii) duration of symptoms, while the other two worked without criteria. Each patient was then assigned to one of five prognostically distinctive clinical categories. Levels of agreement between observers who used criteria were high, but where criteria were not used, overall agreement was lower. When the data in the records was used to classify patients according to clinical groups, similar prognostic results were acquired in two other patient populations. The study indicates that, where appropriate criteria are used, clinical data in medical records is both valid and suitable for use in classifying patient groups.

1294. ULISSE, G. C. **POMR: application to nursing records.** Reading, Mass., & London, Addison-Wesley, 1978, x, 113pp. £4.50

Problem-oriented medical records (POMR) were introduced by Dr. Lawrence Weed during the 1960's. The system is intended to allow nursing staff to collect data and reports on their patients in an organized manner. The book is designed to teach the system by numerous examples and questions at the end of each section. According to their answers readers are referred again to the relevant pages of the text. There is a short bibliography.

HOSPITAL ACCREDITATION AND SIMILAR SCHEMES

See Abstract No. 1248

LEGAL ASPECTS OF HOSPITAL ADMINISTRATION

See also Abstract Nos. 1291, 1377

1295. GORDON, C. A. and CRANBROOK, A. D., editors. **Medical malpractice: counting the cost.** (Oyez Intelligence Reports) London, Oyez Publishing, 1979, v, 54pp. £35.00

This report identifies the key problems arising out of the expansion of claims in respect of medical malpractice in the National Health Service, and is based upon a conference on Medicine and the Law held in December 1978. The report is in six sections which consider: (i) recent developments in medical negligence including consent to treatment, liability of the hospital, the disclosure of medical information and the main problem areas; (ii) the complaints procedure and National Health Service law; (iii) the quantum of damages including the method of assessment, pecuniary and non-pecuniary loss, inflation, parallels with the United States and modern trends in damages; (iv) medical reports in legal proceedings; (v) future developments in the law; and (vi) the role of insurance, including the concept of malpractice insurance, the types of policy available, the effect of the attitude of the medical profession, and the charging of premiums. A table of cases is included together with an appendix composed of two circulars and a memorandum issued by the Ministry of Health.

FINANCE AND ACCOUNTING

See Abstract Nos. 1249, 1285

COSTS

See also Abstract Nos. 1249, 1285

1296. SKAFEL, J. **How to keep the lid on laundry costs.** *Health Care in Canada*, Don Mills, Ont., 1979, Feb., vol. 21, no. 2, pp. 48-49.

The author suggests several ways by which laundry costs may be contained. The problem of different prices being paid by different laundries for the same items can be overcome by standardizing specifications for linen and using group purchasing schemes whenever possible. The laundry manager should have a good working relationship with the plant superintendent and with the hospital's financial department, so that a close control can be kept on the laundry's operation. Energy can be conserved by the installation of a heat recovery system and the use of 145°F water (rather than 165°F) with well insulated piping. Finally, the question of whether the hospital should have its own laundry or whether it would be more economical to participate in a central laundry should also be considered.

FINANCE

See also Abstract Nos. 1365, 1372

1297. GARNER, D. D., LIAO, W. C. and SHARPE, T. R. **Factors affecting physician participation in a state Medicaid program.** *Medical Care*, Philadelphia, 1979, Jan., vol. 17, no. 1, pp. 43-58.

A major problem facing Medicaid is the high proportion of physicians who refuse to participate. A telephone survey was conducted to assess the attitudes and behaviour of a stratified random sample of physicians regarding their participation in a Medicaid programme. They were asked to identify the major advantages and disadvantages of the programme to individual patients, to society and to their medical practice. Non-participants were asked to identify the major reasons why they did not participate in the programme. Medical specialty was the only significant determinant of participation. Inadequate reimbursement, excessive paperwork, patient abuses of the programme, and bureaucratic complexity were among the most prominent factors contributing to non-participation. The implications of these findings are discussed with respect to the role of primary care providers' perceptions in the planning of future national health programmes.

HOSPITAL ACCOUNTING

1298. ASSOCIATION OF HEALTH SERVICE TREASURERS. WELSH BRANCH. **Patient's property, income and allowances.** London, Association of Health Service Treasurers' Research Committee, 1978, [ii], 34pp. £1.50

Health Authorities have an obligation to provide custody of patients' property. This booklet aims to set out the legal position; to give the recommendations of the Department of Health and Social Security; and to suggest procedures which can be applied. The legal guidance is based on the regulations in force in England and Wales as at 31 December 1977. An appendix gives legal precedents as well as listing relevant circulars and departmental memoranda.

1299. GRUNNER, M. EDV-unterstützte Kostenstellenrechnung für Krankenhäuser. **[Computer-based cost accounting for hospitals.]** *Krankenhaus-Umschau*, Kulmbach, 1979, Jan., vol. 48, no. 1, pp. 20-22.

Recent hospital legislation in Western Germany has made necessary a more detailed system of cost accounting than had previously been the case. This paper describes a computer-based system which meets statutory requirements.

CATERING, DIETETICS, KITCHENS

HOSPITAL CATERING

1300. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. CATERING AND DIETETIC BRANCH. **Health service catering: catering for patients in long stay hospitals.** London, D.H.S.S., [1977], 16pp.

Hospitals caring for geriatric, mentally handicapped and long-stay patients have

special catering needs not found in hospitals catering for acute and short-stay patients. Variety and quality become particularly important in long-stay hospitals and the booklet describes the range of dishes and type of meal service required. Appendices give guidance on staffing levels, quantities of food, calorie requirements and a recommended menu.

1301. ROMANELLI, F. **Study shows how to measure energy use, costs in food service.** *Hospitals*, Chicago, 1979, Feb. 1, vol. 53, no. 3, pp. 77-78, 91.

This paper reports a study of energy used in food preparation designed to develop a methodology for estimating energy consumption by various types of equipment and to determine which of four types of equipment (deep-fryer, braiser, deck oven and convection oven) produces the most acceptable product with the least energy consumption. The results showed that the braiser was most energy-intensive; the deep-fryer, the deck oven and the convection oven were similar in consumption of energy.

1302. HERZ, M. L. and SOUDER, J. J. **Preparation systems have significant effect on costs.** *Hospitals*, Chicago, 1979, Jan. 1, vol. 53, no. 1, pp. 89-92.

This paper presents a cost comparison of four catering systems (conventional, convenience, cook-chill and cook-freeze) in hospitals with 100, 250 and 550 beds. The results are summarized in a table and two graphs. Reductions in labour requirements and food costs provided by the cook-chill and cook-freeze systems are the direct result of investment in additional equipment. The increased cost of this capital equipment and the energy needed for its operation are offset by lower labour costs to provide the most economical service. Overall, the cook-freeze system will provide the best opportunity for containment of meal costs. The systems are decreasingly economical in the following order: cook-chill, conventional, convenience. With increasing hospital size, the cost differentials become smaller. The relative costs of the systems are expected to remain the same over the next decade.

LAUNDRIES AND LINEN SERVICE

LAUNDRIES

See also Abstract No. 1296

1303. BIERLEUTGEB, L. Die Industrie als Partner bei der Wäscheversorgung. **[Industry as a partner in laundry work.]** *Österreichische Krankenhaus-Zeitung*, Wien, 1979, vol. 20, no. 3, pp. 131-132, 134.

In mid-1977 the 517-bed hospital at Mödling (Lower Austria) had to decide whether or not to build a new laundry. On the basis of 2.12 kg laundry per patient day it was calculated that there would be 340 tonnes a year and that the total cost per kg if the hospital ran its own laundry would be 16.36 Austrian schillings per kg. A careful monthly analysis of the cost of using a commercial laundry gave a total cost per kg in 1978 of 13.4 Austrian schillings. The decision made to use a commercial laundry was therefore demonstrated to be the right one.

HOSPITAL LINEN AND TEXTILES

See Abstract No. 1310

HOSPITAL DOMESTIC MANAGEMENT

1304. BLOUNT, R. **Housekeeping procedures for the small hospital.** Springfield, Ill., Thomas, 1978, x, 141pp.

The book begins with several chapters dealing with the supervision of hospital domestic staff. For the manager there are chapters on: purchasing; budgeting; records; holiday planning; communications; staff evaluation; and job specifications. The remaining chapters deal with detailed aspects such as: floor care and finishes; machinery; stain removal; germicides; and safety.

HYGIENE IN THE HOSPITAL

1305. WALTERS, E. M., editor. **Papers presented to the annual conference [of the] Infection Control Nurses Association, University of Nottingham, September 1977.** Norwich, Infection Control Nurses Association, [1978], [ii], 54pp.

The annual conference of the Infection Control Nurses Association in 1977 covered a wide range of topics. The four main sections of these proceedings deal with: (i) the modern approach to infectious diseases and virology; (ii) hospital hygiene; (iii) bacteria and their fight for survival; and (iv) infection control in industry. In a section entitled 'the answer to our problems' there is a report of a question and answer session and three papers based on individual experiences.

HOSPITAL INFECTIONS

See also Abstract No. 1308

1306. ALLEN, J. R. **The incidence of nosocomial infection in patients receiving total parenteral nutrition.** In: Advances in Parenteral Nutrition, edited by Ivan D. A. Johnston, pp. 339-377, Lancaster MTP Press, 1978.

This review of the literature (134 references) shows that during the first five years of widespread use of total parenteral notation therapy (TPN) the technique was used frequently without sufficient appreciation of infections and other complications. As more information became available, however, and the complications became better understood, methods of care developed that could prevent them. For infection, this has clearly meant meticulous attention to aseptic technique. It is essential to establish a TPN therapy team with representatives for all departments or services involved to co-ordinate and oversee the care provided and to educate nurses and physicians not on the team. Carefully designed clinical trials are needed urgently to provide solid information about the best techniques and procedures to minimize risks and provide the best possible care.

1307. WALTER, C. W. **Bacterial contamination of intravenous infusions due to faulty technique.** In: Advances in Parenteral Nutrition, edited by Ivan D. A. Johnston, pp. 325-337. Lancaster, MTP Press, 1978.

Reports in the literature show widely scattered rates of septicaemia associated with parenteral therapy. There was insufficient detail to permit comparison of techniques used. Confusion and contradiction were common. A survey of hospital practices revealed little standardization of technique or co-ordination of practices throughout the complex of a general hospital. Practices prevalent during the day bear little relation to those pursued during the evening, at night, over the weekend or on a holiday. Faults in technique which lead to contamination are described with illustrations.

SOURCES OF INFECTION

1308. PHILLIPS, I. and EYKYN, S. **Tracing sources of infection associated with parenteral infusions.** In: Advances in Parenteral Nutrition, edited by Ivan D. A. Johnston, pp. 379-384; discussion, pp. 385-388. Lancaster, MTP Press, 1978.

This paper presents an account of infusion-related bacteraemia in St. Thomas' Hospital, London, where the clinical progress of all patients with bacteraemia has been recorded since 1969. Among 930 cases included in the study no less than 72 (eight per cent) were associated with intravenous therapy. Almost half the cases were caused by *Staphylococcus aureus*. In the 55 cases not associated with intrinsic contamination of the infused fluid, there were 35 with catheters inserted in the jugular vein, 16 in the antecubital fossa and four in the femoral vein. Twenty-four catheters were inserted in the ward, 21 in the intensive care unit, seven in operating theatres, one in the special care baby unit and two in other hospitals. Infection became apparent after about 48 hours of catheterization. None of the cases arose in patients receiving chemotherapy. A convincing source of infection was identified in 39 of the 72 patients.

PREVENTION AND CONTROL

See also Abstract Nos. 1306-1308, 1336

1309. EHRENKRANZ, N. J., HYAMS, P. J. and BOLYARD, E. A. **Consortium upgrades 12 hospitals' infection control programs.** *Hospitals*, Chicago, 1979, Jan. 1, vol. 53, no. 1, pp. 82-84.

The South Florida Hospital Consortium for Infection Control (SFHCIC) currently includes 12 community hospitals ranging in size from 200 to 600 beds. Four persons are employed by SFHCIC; a full-time consulting infection control nurse, two physician epidemiologists who also work in private practice in the field of infectious disease medicine, and a clerk. Each member hospital must employ at least one infection control nurse and must support a technically competent microbiology laboratory. The nurse and physician epidemiologists boost the member hospitals' control efforts through on-site rounds, establishment of group standards, reports on each hospital's performance, on-going education, medico-legal assistance, monitoring of the use of isolation, and evaluation of infection control products.

HYGIENE IN THE OPERATING THEATRE

1310. DANKERT, J., ZIJLSTRA, J. B. and LUBBERDING, H. **A garment for use in the operating theatre: the effect upon bacterial shedding.** *Journal of Hygiene*, Cambridge, 1979, Feb., vol. 82, no. 1, pp. 7-14.

In operating theatres the emission of bacteria into the air from human skin can be prevented by wearing clothes of impervious material. In the study described, shedding of bacteria from 20 persons wearing an operating theatre suit made of 65 per cent polyester and 35 per cent cotton (Diolen) was investigated in a test chamber and compared with the amount shed when normal cotton clothing was worn. The use of the Diolen suit resulted in a 50 to 75 per cent reduction in the number of bacteria carrying particles in the air of the test chamber, and in the operating room when everyone present wore the suit. The addition of knee-high boots reduced the dispersal of colony forming units still further. Although slightly less effective than Ventile clothing, the Diolen suit is more appropriate for general use in the operating theatre.

1311. LABRYGA, F. Funktionell-bauliche Anforderungen an Operationsabteilungen. **[Functional and structural requirements for operating suites.]** *Krankenhaus*, Stuttgart, 1978, Nov., vol. 70, no. 11, pp. 438-442.

A study of the hygiene requirements for operating suites leads to the following conclusions: all operation services should be centralized; there should be airlocks for patients, staff and goods; there should be separate 'aseptic' and 'septic' theatres; the number of theatres in a suite should be limited and where necessary more than one suite should be provided; there should be a separate supply corridor for clean goods; and for each theatre there should be an ante-room, a post-operative room and one, or possibly two, washrooms. The theatre should be as clear as possible and the necessary fixed or mobile equipment should be easy to clean and disinfect.

STERILIZATION

1312. PRUGNAUD, J. L. and others. La compresse en non-tissé. **[Non-woven dressings.]** *Techniques Hospitalières*, Paris, 1979, April, vol. 34, no. 403, pp. 69-72, 75-77.

The history and methods of manufacture of non-woven fabrics are outlined. Consumption for medical use was 6,400 tonnes in 1976 and dressings represented only 1.6 - 2 per cent of total European production of non-woven fabrics. Only five manufacturers provide non-sterile non-woven dressings on the French market. The authors present the results of tests in which they compared the behaviour of dressings made of cotton gauze and of non-woven viscose fabrics in regard to breaking load, resistance to abrasion, chemical analysis, and sterilization. These results suggest that non-woven dressings are suitable for use in disinfecting the skin and protecting cicatrizing wounds from bacteria, but not for cleaning dirty wounds because they lack abrasiveness, nor for oozing wounds because they tend to disintegrate when wet and contain surface-active and water-soluble substances. Eight tables of information and results and two photographs are included.

AIR HYGIENE

See also Abstract No. 1310

1313. ARNOLD, R. **O.R. gas hazard can be minimized.** *Health Care in Canada*, Don Mills, Ont., 1979, March, vol. 21, no. 3, pp. 34-35.

There is increasing concern in many Canadian hospitals about the control of waste anaesthetic gases, which are a major cause of environmental pollution in operating theatres. Increased rates of hepatic disease, cancer and renal disease are associated with working in the operating room, and females run the risk of spontaneous abortion. The Canadian Anaesthetists' Society have recommended the use of scavenging systems to reduce the level of trace anaesthetic gases in the operating room air. Air monitoring and regular equipment maintenance to avoid leakages are also important. Dangerous concentrations of ethylene oxide from sterilizers can also be avoided if the door near the sterilizer is opened slowly and staff refrain from breathing the gas mixture inside the chamber until the gas has diluted to a safe level. Adequate aeration of all supplies processed in the ethylene oxide sterilizer is vital. If proper precautions are taken, the risks from ethylene oxide gas are negligible.

1314. KOEMEESTER, A., MES, J. and BRIMICOMBE, R. Gezondheidsrisico's voor het nageslacht van operatiekamer-personeel. **[Health risks for the offspring of operating room staff.]** *Tijdschrift voor Sociale Geneeskunde*, Amstelveen, 1979, March 21, vol. 57, no. 6, pp. 196-200.

The paper presents findings of international research into mutagenic and teratogenic effects of anaesthetic gases on offspring of operating theatre staff. Effects of general exposure and of individual gases, such as nitrous oxide and halothane, are discussed and details are given concerning spontaneous abortions, congenital abnormalities and stillbirths. Though research has not yet been conclusive, it is recommended that anaesthetic gases be removed from operating theatres as much as possible by good ventilation and suction systems and that regular tests for leakage of anaesthetic equipment and measurements of gas concentrations be carried out. Further proposals are: (i) regular medical examinations of staff; (ii) closer contact between the hospital staff's physician, anaesthetists and medical and occupational health inspectors; and (iii) the setting up of a national working group to co-ordinate epidemiological research, develop systems for environmental and biological monitoring, provide information and collate data for comparisons with animal tests.

1315. ROSE, H. D. and HIRSCH, S. R. **Filtering hospital air decreases aspergillus spore counts.** *American Review of Respiratory Disease*, New York, 1979, March, vol. 119, no. 3, pp. 511-513.

Counts were taken of airborne spores in a new hospital with filtered air, following a reported decrease in hospital acquired infection with *aspergillus* organisms. Similar studies were carried out at a nearby hospital in a ward with open windows. The total spore count inside the hospital with filtered air was significantly less than inside the ward with open windows. The total count of *aspergillus* organisms in the filtered air was likewise significantly smaller. The filtering system, which is described, was thus success-

ful in removing most, if not all, airborne spores. This resulted in a reduction in infection. Any organisms which remained may have originated within the hospital.

PERSONAL HYGIENE OF THE PATIENT

See Abstract No. 1264

SAFETY MEASURES

ACCIDENTS, GENERALLY

1316. MANCHESTER UNIVERSITY. DEPARTMENT OF COMMUNITY MEDICINE. UNIT FOR CONTINUING EDUCATION. **Prevention of accidents in hospital: proceedings of a seminar held in conjunction with the Medical Commission on Accident Prevention, December 4th-5th 1978, Holly Royde College, Manchester.** Manchester, University of Manchester, Department of Community Medicine, [1979], 33pp. £0.75

This seminar held on accident prevention in hospital was concerned with an in-depth examination of the need for increasing awareness that hospitals are not safe sanctuaries. The eight papers considered a variety of aspects including: health and safety at work; a pilot study of accidents in hospitals in 1975; the role of the Employment Medical Advisory Service; the organization aspect of accident prevention services in hospital; the clinical aspects of communicable disease in hospital; microbiological hazards in relation to hospital and laboratory staff; notifiable disease in hospital; and health education in hospitals in relation to accident prevention. The discussions that took place after each paper are also presented, and a list of participants and speakers is included.

FIRES AND FIRE PREVENTION

1317. SOUTHAMPTON AND SOUTH WEST HAMPSHIRE HEALTH DISTRICT and HAMPSHIRE AREA HEALTH AUTHORITY (TEACHING). **Planning for the movement of hospital patients in a fire emergency.** [Southampton], Southampton and South West Hampshire Health District, 1978, 56pp. £1.00

Circular HC(78)4 from the Department of Health and Social Security drew the attention of administrators to the need for Nominated Officers (Fire) to be appointed. These officers have the onerous task of determining whether fires are serious enough to require evacuation. Some guidance is given on criteria for these decisions in several of the papers presented here. Other papers deal with the roles of different hospital staff, including nurses, administrators and medical staff. Two further papers deal with the importance of the ambulance officer and the help which the police can give.

1318. SCHELEPA, H. Brandschutzorganisation in Krankenanstalten. **[Organization of fire prevention in the hospital.[** *Österreichische Krankenhaus-Zeitung*, Wien, 1979, vol. 20, no. 3, pp. 173-174, 176-179.

Austrian legislation on fire prevention is briefly outlined and its application to hospitals set out. A fire prevention officer should be nominated with the following responsibilities: preparation of fire prevention procedures; determining the action of the staff in case of fire; regular inspection of fire safety measures; preparation of a fire prevention plan; training of staff; and the maintenance of fire prevention records. The paper includes a model set of fire prevention orders for a hospital.

THE PATIENT

WELFARE OF THE PATIENT

See also Abstract Nos. 1332, 1354, 1387

1319. SCHWARZENAU, A. and others. Weckzeiten im Krankenhaus, Bedürfrisge des Patienten—Planung und Organisation. **[Waking times in the hospital: the patient's needs—planning and organization.]** *Deutsche Krankenpflegezeitschrift*, Stuttgart, 1979, March, vol. 32, no. 3, pp. 114-121.

An enquiry among 50 patients in six Berlin hospitals revealed that one was washed at 11.30 p.m., four were wakened between midnight and 2 a.m., five between 2 and 4 a.m., 15 between 4 and 5 a.m., 23 between 5 and 6 a.m., and only one between 6 and 7 a.m. A working group has been looking into the problem of early wakening of patients. It puts forward a scheme, described in detail in this paper, under which no patient would be wakened before 7 a.m. It is based on a 36-bed acute ward. There would be four nursing shifts: 6.18 to 14.42; 12.10 to 20.24; 14.00 to 22.24; and 21.52 to 7.00. During the first two shifts a sister, three nurses and two student nurses would be on duty; during the third shift, two nurses; and during the night shift one nurse.

1320. SURREY AREA HEALTH AUTHORITY. **Guidelines to staff on the management of violent or potentially violent patients.** [Guildford], Surrey Area Health Authority, [1978], 16pp.

Department of Health and Social Security Circular HC(76)11 highlighted the problems of controlling violent patients and the legal problems this presents. This booklet deals with: the identification of potential violence; prevention of violence; restraint of violence; and the procedure to be adopted after a violent incident. The last chapter deals with lessons to be learnt from an incident of this kind. In an appendix the Chief Constable of Surrey gives a brief account of the role of the police in assisting with problem patients.

1321. GENVERT, G. and others. **Isolation information booklet stimulates dialog, allays fears.** *Hospitals*, Chicago, 1979, Feb. 1, vol. 53, no. 3, pp. 72, 74-75.

Isolation for hospital or community-acquired infection can be a bewildering and

potentially stressful situation for the hospital patient and his family. Proper education is essential in order to minimize these fears and provide optimal medical care. A booklet has been prepared to supplement the verbal explanations that should be given by hospital staff about the rationale and details of the isolation procedures. The booklet is based on concerns expressed by isolated patients in interviews with epidemologists. The booklet is presented in a question and answer form; excerpts are reproduced.

1322. LANE, D. S. and EVANS, D. **Measures and methods in evaluating patient education programs for chronic illness.** *Medical Care*, Philadelphia, 1979, Jan., vol. 17, no. 1, pp. 30-42.

Patient education provides a vehicle for increasing the self-management of chronic illness and promoting modifications of life styles, which are considered important strategies for prevention. Evaluating the impact of such programmes is complex and poses a number of methodological and technical problems. Outcome measures of patient education programmes are defined and reviewed in terms of the existing evaluation literature and the authors' own studies using diabetes as a prototype condition. Important dimensions of adaptation are outlined and indices to measure it discussed in an effort to examine aspects of educational programmes directed at maintaining quality of life. Factors which influence outcome variables are identified and include: patient factors (age, ethnic, socio-economic, cultural, personality and emotional); disease factors (severity of illness, age of onset, length of illness, mode of therapy); and system factors (patient's location in the health care-system, relation of teaching programme to other health care provision). The effects of these factors are described, including their implications for research design.

1323. SECHRIST, K. R. **The effect of repetitive teaching on patient's knowledge about drugs to be taken at home.** *International Journal of Nursing Studies*, Oxford, 1979, vol. 16, no. 1, pp. 51-58.

This study was carried out to test the effects of repetitive teaching about drugs to be taken after discharge from hospital, compared with a single teaching period. A teaching and testing guide was developed and 41 patients took part, 17 in the repetitive teaching group and 24 in the single teaching group. The two variables of age and educational level were analyzed for their relationship to the scores obtained. Questions most frequently not answered related to the name of the drug and possible side effects. All patients in the repetitive teaching group knew their dosage schedule, but only 35 per cent answered all nine questions correctly. Although this percentage was a significant improvement on the results from the single teaching group, the test indicated that further study is needed to determine the number of repetitions required to ensure learning and the effect of repetition on long-term memory and compliance.

1324. SUTULA, D. A. **Students climb on the CPR bandwaggon.** *Hospitals*, Chicago, 1979, Feb. 1, vol. 53, no. 3, pp. 67-68.

East Liverpool (Ohio) City Hospital has developed a three-part programme of health education for the community: (i) cardiopulmonary resuscitation classes for the public; (ii) a special cardiopulmonary programme for high-school pupils; and (iii) a

series of general health education programmes for the public. The project is run jointly by the community relations and in-service education departments.

1325. MIND. **Patients rights handbook.** London, MIND, 1978, [ii], 26pp. £0.70

The laws affecting the mentally ill are numerous and complex. Sections of this guide deal with civil and criminal law; the various forms of hospital treatment; and the rights of the patient. An appendix gives quotations from the relevant sections of the different Acts and a glossary is included.

1326. BURKERT, A. Kind und Eltern im Krankenhaus auch ein Vorschlag: Elternschulung? **[Children and parents in the hospital: a proposal for the training of parents.]** *Deutsche Krankenpflegezeitschrift*, Stuttgart, 1979, April, vol. 32, no. 4, pp. 209-210.

While much attention has been paid to the preparation of young children for a stay in hospital very little has been done to ensure that parents (and especially mothers who are to be admitted to hospital with their children) know about conditions in children's hospitals and how to care for children there. It is suggested that parents should be given instruction to enable them to make a proper contribution to the welfare of their children. Paediatricians, nurses, child psychologists and hospital administrators should take part in these courses.

HOSPITAL SOCIAL WORK

1327. REGENSBURG, J. **Toward education for health professions.** New York & London, Harper & Row, 1978, xii, 244pp. £7.50

Biological, psychological and social forces all affect health and interact with each other; here they are dealt with mainly from the social work point of view. Social work traditionally has been deeply rooted in knowledge and skills concerned with human relationship, with the interaction between human beings and the environment, and with the human ability to adapt to and cope with the pressures and demands of the environment. The impacts of illness and disability on patients; on their relatives and friends; and on the health services are considered. The final chapter gives concluding comments on the practice of hospital-based social work in the light of the different factors and groups.

THE GENERAL PRACTITIONER AND HIS PATIENTS

See Abstract No. 1374

TRANSPORT OF PATIENTS

See Abstract No. 1356

HOSPITAL CARE

See also Abstract Nos. 1275, 1279, 1285, 1355, 1362, 1363, 1388, 1398

1328. SCOTTISH HEALTH SERVICE. COMMON SERVICES AGENCY. MANAGEMENT EDUCATION AND TRAINING DIVISION. **Study sessions report: management of pressure areas, 13 & 22 September 1978, Scottish Health Service Centre.** Edinburgh, Scottish Health Service Centre, 1978, 16pp.

The aim of the study sessions was to give health service staff the opportunity to discuss the management of pressure sores and also to display new mechanical and pharmacological aids to prevent and treat pressure trauma. The two papers given considered pressure sore research, and prevention and treatment.

1329. SANAZARO, P. J. **The private initiative in PSRO.** *Hospitals*, Chicago, 1979, Jan. 1, vol. 53, no. 1, pp. 61-64.

Private Initiative in Professional Standards Review Organisations (PIPSRO) was founded in 1973 by the American Association of Foundations for Medical Care, American College of Physicians, American Hospital Association and American Society of Internal Medicine. Between August 1974 and June 1976, PIPSRO collaborated with five PSRO-precursor organizations to study their implementation of PSRO. In particular, the management of PIPSRO directed their attention to what they considered the most important issue—federal regulation of professional mechanisms for ensuring the quality of care. Alternatives to the federal government's approach were studied and it was concluded that the special functions of PSROs in regulating quality assurance should be to ensure that a basic standard of care is maintained for all Medicare and Medicaid patients.

1330. FRISK, M. and MADSEN, M. Projektforløb ved forudsigelse og forebyggelse af tryksår: det väsentligste er at profylakse startes tidligst muligt. **[Progress report on a project in prognostication and prevention of pressure sores: it is essential to start prophylaxis as early as possible.]** *Sygeplejersken*, København, 1979, March 28, no. 13, pp. 4-11.

A project group was set up at the Skin Clinic of Copenhagen's Kommunehospital to compare and contrast the various methods of preventing bedsores. After assessment on admission, patients were alloted an air, water, or control material mattress by means of a random system. All patients with a high risk of pressure sores, however, were allocated special mattresses. Problems arising during the project were: (i) the beds became six cm higher, making physical work harder; (ii) bedpans and bed-bathing required a staff of two; (iii) it proved difficult to get patients in and out of bed; (iv) the beds felt cold, solved by putting woollen under-blankets on; (v) cardiac arrest patients had to be put on the floor; (vi) patients with pelvic, columna and femoral fractures could only use the air mattress; and (vii) patients with heart-lung conditions needed a special technique to help them sit up. The project has shown that both the alternating air pressure mattress and the water filled mattress are equally effective in preventing bedsores, the important point being to commence prophylaxis as early as possible in the acute phase. The article is illustrated with four interior photographs, and includes copies of the instructions and questionnaire given to staff. (See also Hospital Abstracts vol. 19, no. 949.)

1331. POULSEN, C. L. Sygeplejeforskning: Målemetoder for kvalitet i sygeplejen. **[Nursing research: methods for assessing the quality of nursing.]** *Sygeplejersken*, København, 1979, March 28, no. 13, pp. 20-23.

A number of viable analytical methods and instruments exist for assessing the quality of professional work, including nursing. Quality assessment is based on defining the frame of reference of the department or ward concerned. An operational description is made of the aims of the department, laying down the ways in which the given tasks should be tackled and formulating these as standards. These standards define the quality of the nursing tasks required. Assessment of quality comprises comparing one's observations and the results of one's interviews and questionnaires with these standards. Nursing is defined by Leawitt as an integrated system comprising structure, technology, staff and nursing tasks—conversations, instruction, patient hygiene, and communication with relations. High quality in nursing can be defined as an ethical attitude, or as optimal utilization of the structural, technological and/or personnel facilities: the department concerned must define its own standard of quality. The article is illustrated with the three questionnaires employed, and diagrammatic representations of views on nursing of Leawitt, Florence Nightingale, Virginia Henderson and Callista Roy. There are 12 references (four English).

1332. MANGELSDORFF, A. D. **Patient satisfaction questionnaire.** *Medical Care*, Philadelphia, 1979, Jan., vol. 17, no. 1, pp. 86-90.

The development of a patient satisfaction questionnaire using factor analytical techniques is described. The final version has 19 items assessing attitudes towards physicians, nurses, medical auxiliaries, professional interest, courtesy, quality of care, adequacy of information and convenience of the clinic. It uses a five-point Likert scale—completely dissatisfied, mostly dissatisfied, neutral/undecided, mostly satisfied, completely satisfied. Validity was assessed using correlations with specific criteria items.

1333. HOHMAN, J. **Nurse mentor system cuts costs, boosts quality of patient care.** *Hospitals*, Chicago, 1979, Jan. 1, vol. 53, no. 1, pp. 93-94, 101.

The nurse mentor system combines the mentor concept used in industry and the team concept used in traditional health care delivery. It was developed at the Children's Hospital of San Francisco as an antidote to four problems: a chronic shortage of registered nurses; rising costs; lack of a mechanism to provide recognition for individual inter-personal and clinical expertise; and lack of an on-going staff development programme. The nurse mentor, aided by two or three assistants, is responsible and accountable for total patient care for a specific group of patients for each eight hour shift. She acts as a patient advocate and counsels, teaches, coaches, supports, promotes and inspires the members of her team.

DISCHARGE OF PATIENTS

See Abstract No. 1390

CONVALESCENT CARE, CONVALESCENT HOMES

1334. REGISTERED NURSING HOME ASSOCIATION. **Reference book—1979: registered nursing homes in the UK and Republic of Ireland.** London, Registered Nursing Home Association, 1979, 111pp.

This is the sixth edition of this guide to independent (charitable and otherwise) nursing homes in the British Isles. The establishments covered are those homes registered to provide treatment outside the National Health Service rather than old peoples' homes in general. There is an index by towns to supplement the listing by Health Authority areas.

HOME CARE, AFTER-CARE

See Abstract Nos. 1360, 1378, 1390

SPECIAL DEPARTMENTS

OPERATING SUITES

See also Abstract Nos. 1259, 1310

1335. **'Ideal' design retrofits operating rooms to accommodate ophthalmic and general surgery.** *Hospitals*, Chicago, 1979, Feb. 16, vol. 53, no. 4, pp. 36-38.

Although the demand for ophthalmic surgery is usually insufficient to warrant operating theatres devoted only to that speciality, joint use with general surgery has seldom been completely satisfactory, the main problem being the ceiling-supported microscope column used in ophthalmic surgery. In redesigning two theatres for joint use, St. Mary's Hospital and Medical Center, San Francisco, has overcome the problem by installing the column six inches higher than the original technical drawings suggested. Several minor but acceptable alterations and compromises were required. These are described and illustrated by plans and diagrams.

1336. LANNELONGUE, J. and others. La désinfection des salles d'opération. **[The prevention of infection in operating rooms.]** *Hospitalisation Privée*, Paris, 1979, Feb., no. 190, pp. 7-14.

This is an assessment of the advantages and disadvantages of the various methods of preventing infection in the operating theatre: (i) classical methods of cleaning the theatre such as soap and water; (ii) sterile air conditioning; (iii) new methods and equipment such as mobile apparatus in which air is cycled through a collection of filters; ceilings with filters attached; glasshouses or tents; and bubbles. No specific method is selected but the general conclusion is that the levels of contamination must be controlled and the problems of organization and hygiene solved in the individual operating block. It is preferable to have a conventional theatre with a highly disciplined team than a sophisticated system which does not always work properly. Twelve photographs are included.

ANAESTHESIA

See also Abstract Nos. 1313, 1314

1337. **Symposium: recovery from anaesthesia.** *Journal of the Royal Society of Medicine*, London, 1979, April, vol. 72, no. 4, pp. 270-280.

Four papers consider various aspects of the work of the recovery room. The first outlines the development of recovery rooms and describes the one at Addenbrooke's Hospital, Cambridge, which has 12 bed spaces and serves a suite of eight operating theatres. The bed-head units provide ample accommodation for all likely requirements. The relationship of the recovery room to the intensive care unit is discussed. The second paper discusses the pattern of work in the recovery room and considers: (i) the size of the room in relation to the number of theatres; (ii) equipment and services; (iii) the length of stay; and (iv) the records to be kept. The third paper deals with the recovery room as a nursing service, with special reference to Whipp's Cross Hospital, where a nursing officer has been appointed solely for the recovery areas. The work is organised to give the patient constant attention from the anaesthetic room to the recovery room, the nurses having full knowledge of the case in question. There is a considerable variation in staff numbers and training in recovery rooms. The final paper discusses the medical complications which may arise in the recovery room and shows how they may be dealt with effectively.

1338. ASSOCIATION OF ANAESTHETISTS OF GREAT BRITAIN AND IRELAND. **Working party on manpower and staffing: report.** (Chairman: Dr. E. B. Lewis). [London], Association of Anaesthetists of Great Britain and Ireland, 1978, 12pp.

During 1974 consultant anaesthetists in 17 districts throughout England were asked to fill in questionnaires about their work. The report based on the survey is in three parts: (i) work load including the number of anaesthetics given and number of anaesthetic and para-anaesthetic sessions; (ii) staffing available; (iii) staffing compared to work load with some consideration of problems caused by study leave and staff shortages. Staff levels were found to be below those recommended by the Faculty of Anaesthetists and a majority of foreign staff in some grades was discovered. The report calls for consideration of the totality of the anaesthetist's responsibilities, the demands of training, the realities of the staffing situation and the rapid expansion of certain parts of anaesthetic departments.

PHARMACY

See also Abstract No. 1323

1339. BAUERNFEIND, U. Computer in der Apotheke des Nürnberger Klinikums. **[Computers in the Nuremberg Hospital's pharmacy.]** *Krankenhaus*, Stuttgart, 1978, Nov., vol. 70, no. 11, pp. 426-429.

The central pharmacy of the Nuremberg municipal hospitals serves 14 hospitals with a total of 2,740 beds and fills daily an average of 1,500 orders for drugs and chemicals. In 1977 it was decided to install the pharmacy's own computer, a Nixdorf 8870/6 magnetic disc system. Details of the equipment are given as well as of the programming.

The latter includes: ward data (daily lists, stocks); monthly statement on ward consumption with detailed statistical breakdown; stores monitoring, with alarms when stocks fall below minimum levels; automatic order writing for individual firms; statistical assessments; and recording of stores movements and use.

1340. CONNER, C. S., WATANABE, A. S. and RUMACK, B. H. **Drug information—the problems and some solutions.** *Drug Intelligence & Clinical Pharmacy*, Hamilton, Ill., 1979, Feb., vol. 13, no. 2, pp. 86-93.

The major problems with current sources of drug information are time involvement, accessibility of data, completeness, validity of information, appropriateness and currency. What are needed are methods of providing rapid access to current, evaluated drug information. Many solutions are available, but this paper discusses particularly: clinical pharmacologists, specialists and colleagues; clinical pharmacists; drug information centres; and DRUGDEX, a computer-output microfiche drug information system. The DRUGDEX system consists of three separate but integrated microfiche systems: the index, drug evaluations, and drug consults. Examples of a drug evaluation and a drug consult are reproduced.

1341. SCHOTTEN-PLANUS, I. De la distribution des médicaments à l'hôpital. 3e partie. **[Drug distribution in the hospital, part 3.]** *Techniques Hospitalières*, Paris, 1979, March, vol. 34, no. 402, pp. 61-74.

Detailed instructions are given for the organization of the hospital pharmacy drug distribution system, covering: receipt and checking of pharmaceutical products; drug storage; receipt and checking of empty packages returned from the operational (i.e. care unit) pharmacies; receipt, checking, preparation, loading, and delivery of orders; receipt, storage, and distribution of bulky articles; and what to do with returned drugs. These are followed by recommendations on the preparation of drugs in the hospital, the distribution of dressings, accessories, and mineral water, and a final chapter where the structure and functions of the hospital pharmacy are summarized.

LABORATORIES

1342. WORLD HEALTH ORGANIZATION. REGIONAL OFFICE FOR EUROPE. **The role of the hospital laboratory in public health: report on a working group, Stockholm, 8-12 May 1978.** (ICP/ATH 004) Copenhagen, WHO Regional Office for Europe, 1978, [iii], 15pp.

In 1978 the World Health Organization called a meeting to define the role of the hospital laboratory in public health and its collaboration with the public health laboratory network. The report attempts to assess present and future trends and to consider how all types of health laboratory service might be rationalized. The three sections of the report are: (i) functions of hospital laboratories in relation to public health; (ii) development of hospital laboratories; and (iii) collaboration and co-ordination between various types of health laboratory.

1343. KOLMODIN-HEDMAN, B. and HEDSTRÖM, L. KS-undersökning bland labbpersonal: var femte graviditet leder till missfall. **[Karolinska Hospital laboratory staff study: every fifth pregnancy resulted in a miscarriage.]** *Vårdfacket*, Stockholm, 1979, March 8, vol. 3, no. 5, pp. 54-55.

The Karolinska (Caroline) Hospital in Stockholm has for several years studied the blood picture of laboratory staff exposed to organic solvents. The laboratory assistants proved to have a higher frequency of chromosomal damage than random controls. There was also an increased frequency of chromosome rupture in their children. In anaesthetic nurses, smoking and exposure to anaesthetic gases has led to increased frequency of spontaneous abortion and foetal damage. 109 laboratory staff in regular contact with toluene, methylene chloride, chloroform, acetone and methanol (some of whom also work with radioactive isotopes) were compared with 70 admissions department staff. Of the 109 exposed women, 65 had children, 44 had none, and four were pregnant; compared with 24 control women with children, 38 without children and four pregnant. There was no increase in frequency of malformations or illness in the children of exposed women. The frequency of occurrence of spontaneous abortions in the material as a whole was 11.6 per cent; 18.2 per cent in exposed pregnancies and 6.7 per cent in unexposed. Pregnancies in mothers over 35 were excluded. The difference is significant by the Mantell-Haenszel test. The article includes a photograph of an organic solvent vapour extractor system developed by the authors, and statistics on which the conclusion is based.

1344. COHEN, R. and others. Le contrôle de qualité des analyses de biologie médicale dans les laboratoires des Hospices Civils de Lyon. **[Quality control of biomedical tests in the laboratories of the Lyons Civil Hospitals.]** *Techniques Hospitalières*, Paris, 1979, April, vol. 34, no. 403, pp. 40-46.

The authors describe in some detail routine quality control tests on biomedical analyses which have been used in the laboratories of all the Civil Hospitals in Lyons for the past seven years. They have led to an improvement in the quality of the analyses and to standardization of methodologies within all the hospitals in the group. The description includes two tables which summarise accuracy and exactitude controls, a histogram of urea analysis values, tables of results of urea analysis, blood analysis.

BLOOD TRANSFUSION DEPARTMENT

1345. ABBOTT, R. D., FRIEDMAN, B. A. and WILLIAMS, G. W. **Recycling older blood by integration into the inventory of a single large hospital blood bank: a computer simulation application.** *Transfusion*, Philadelphia, 1978, Nov./Dec., vol. 18, no. 6, pp. 709-715.

The purpose of this study was to determine with the use of a computer simulation the effects of integrating a variable number of units of 10-day old blood into the inventory of a large single hospital blood bank. The analysis involved separate consideration of the recycling of 30, 60, 90, 120, 180, 240, 300 and 360 units of 10-day-old blood with one, three and five deliveries per week into the modelled blood bank inventory. With one delivery per week and a 30 per cent outdate rate for blood 10 days old or older at the hospital or hospitals recycled, the net saving per week by recycling these variable

quantities is 5,4,13,17,7,0,–17, and –50 units; for a 50 per cent outdate rate, the net saving achieved is 11, 16, 31, 41, 43, 48, 43 and 22 units. Possible net savings of blood based on three and five deliveries per week and other outdate rates are also given. The frequency of blood delivery has no significant effect on the net saving of blood in the recycling plans evaluated. The implementation of an automatic blood recycling programme, which is a practical and effective method for reducing blood outdating in a multi-hospital regional blood system, is discussed in detail.

1346. ALLEN, F. H. and others. **Regional blood center automation: computer surveillance of donor blood processing.** *Transfusion*, Philadelphia, 1978, Nov./Dec., vol. 18, no. 6, pp. 716-721.

Accurate labelling is of crucial importance in a blood bank. Mislabelling is usually caused by clerical errors in the transcription of data rather than by technical errors in the laboratory. The authors of this paper believe that automation of blood processing and labelling can eliminate most errors. The system outlined uses a mini-computer to check all the essential steps, including the labelling.

DIAGNOSTIC X-RAY DEPARTMENT

1347. REINOLD, D. A. **Are mobile CT scanners in your hospital's future?** *Hospitals*, Chicago, 1979, Feb. 1, vol. 53, no. 3, pp. 60-65.

Some of the major considerations involved in the decision to use mobile computerized tomography scanners are: needs assessment; staff resources; facility and equipment; and administrative factors. The paper also describes the current status of reimbursement, analyzes physician acceptance and provides an example of a mobile scanner.

1348. ELLIOTT, A. T. and others. **The provision of a district nuclear medicine service.** *British Journal of Radiology*, London, 1979, May, vol. 52, no. 617, pp. 419-420.

Departments of nuclear medicine have been established mainly in the major hospitals and this necessitates the transport of patients from other hospitals, resulting in a number of problems. Following the introduction of mobile cameras, an alternative procedure is to take the service to the patients. This paper describes a pilot study in which a service was provided on one day a week to a daughter hospital of St. Bartholomew's Hospital, London, using a Searle LEM camera. It is concluded that the operation of a mobile system offers a useful and cost-effective means of extending nuclear medicine services to a greater proportion of patients throughout a district or area.

RADIOTHERAPY DEPARTMENT

See also Abstract No. 1348

1349. FREDRICKSON, D. H. and others. **Experience with computer monitoring, verification and record keeping in radiotherapy procedures using a Clinac-4.** *International Journal of Radiation Oncology, Biology, Physics*, New York, 1979, March, vol. 5, no. 3, pp. 415-418.

A computerized therapy record system was tested at Stanford University in California.

Daily records were kept by computer of radiation therapy. The records also included patient identification information, diagnosis and details of the therapy prescribed. Treatment machine parameters and doses were recorded and checked each time and the results are presented for 46 patient records kept on the computer. Although the system performed adequately there was little saving in time or resources. In this instance, therefore, a computerized system was not implemented.

REHABILITATION

See also Abstract Nos. 1255, 1368, 1391-1393

1350. NEWMAN, C. E. **Rehabilitation can be cost containment device.** *Hospitals*, Chicago, 1979, March 1, vol. 53, no. 5, pp. 45-46.

Early effective rehabilitation can help to contain costs in four ways: (i) appropriate referral from acute care hospitals to rehabilitation services of certain types of cases; (ii) early referral to rehabilitation care; (iii) the use of alternative systems of care; and (iv) the health education of patients and families.

PHYSIOTHERAPY DEPARTMENT

1351. WATERMAN, A. G. S. **An investigation into differences in preferred learning styles among students in the schools of occupational therapy, remedial gymnastics and physiotherapy at the Combined Training Institute of the University Hospital of Wales.** Cardiff, University Hospital of Wales Combined Training Institute, 1979, [ii], 45pp.

Despite the increasing specialization of Health Service disciplines there are strong financial arguments for educating differing groups of students together. This study is based on 199 students from three allied remedial professions. The findings show considerable differences in learning styles and the norms adopted by the professions. Some observations are made upon the possible consequences of this study for both education administrators and teachers, together with some consideration of possible directions for further research.

DEPARTMENTS FOR SPECIAL THERAPY

See Abstract No. 1369

SPECIAL HOSPITALS AND UNITS

OUT-PATIENT

See also Abstract No. 1373

1352. HANNINGTON-KIFF, J. G. Schmerzkliniken in Grossbritannien. **[Pain clinics in Great Britain.]** *Deutsche Medizinische Wochenshrift*, Stuttgart, 1979, March 23, vol. 104, no. 12, pp. 419-421.

In the 186 health districts of England and Wales there are between 30 and 40 pain

clinics which have developed from the efforts of individual anaesthetists to improve the treatment of pain in district hospitals. The clinic described in this paper is one of three coming under the Surrey Area Health Authority. An analysis of 100 patients treated consecutively gave the following results: 73 per cent were over 60 years of age; the most common diagnoses were: post herpetic neuralgia (24 per cent), cancer (19 per cent) and ischaemic feet (15 per cent); and referrals were from: general practitioners (40 per cent); general surgery (29 per cent); orthopaedic surgery (23 per cent); hospital physicians (six per cent); and gynaecologists (two per cent). The treatment given is briefly described.

1353. DUTTON, D. B. **Patterns of ambulatory health care in five different delivery systems.** *Medical Care*, Philadelphia, 1979, March, vol. 17, no. 3, pp. 221-243.

This study describes patterns of ambulatory care amongst patients in Washington, D.C., using five different sources of health care: individual general practitioner; 'fee-for-service' group practice; 'prepaid' group practice; public clinics; and hospital out-patients. Comparisons reveal substantial differences; the poor used out-patient departments and public clinics and were not encouraged to seek follow-up care. Under the prepaid system patients were encouraged to seek preventive and acute care whilst follow-up care was readily available. A perverse effect of the 'fee-for-service' system was that patients were reluctant to go for treatment whilst doctors had great incentives to encourage follow-up care. The findings indicate that a prepaid system may be the most satisfactory.

1354. SAFER, M. A. and others. **Determinants of three stages of delay in seeking care at a medical clinic.** *Medical Care*, Philadelphia, 1979, Jan., vol. 17, no. 1, pp. 11-29.

Factors affecting delay before seeking treatment for the first time were studied in patients at clinics in a major, inner city hospital. On the basis of the patients' retrospective reports, the total time from first noticing a symptom to the seeking of treatment was divided into three sequential stages: (i) appraisal delay—time taken to appraise a symptom as a sign of illness; (ii) illness delay—time taken from deciding one is ill until seeking professional medical care; and (iii) use delay—time from the decision to seek care until going to the clinic and using its services. Patients experiencing a very painful symptom and patients who did not read about their symptom had a short appraisal delay. Patients with old symptoms and those who imagined possibly severe consequences of their illness had long illness delays. Use delay was shortest for patients who were not concerned about the cost of treatment, who had a painful symptom, and who were certain that their symptom could be cured. Patients who had short total delays were those who did not have a competing personal problem and who had a painful symptom. It is concluded that different factors mediate delay in each of the three stages and that studies which use only a single measure of total delay are likely to be of limited value in understanding delay.

1355. FREIBERG, L. **Substitution of outpatient care for inpatient care: problems and experience.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1979, vol. 3, no. 4, pp. 479-496.

The substitution process is complex and often depends on factors which are subtle or

non-quantifiable. These factors introduce a downward bias in estimates of substitution costs and an overestimation of what will be accomplished. The author identifies four conditions which may allow substitution to take place: (i) technological innovation; (ii) changes in organization; (iii) better facilities outside hospital; and (iv) better educated individuals more able to look after themselves. Attempts however, by the American government to introduce substitution have been poorly planned and have been generally unsuccessful.

CASUALTY AND ACCIDENT

See also Abstract No. 1389

1356. MURPHY, D. **Private sector public service.** *Emergency*, Carlsbad, Calif., 1979, Jan., vol. 11, no. 1, pp. 36-39, 41-42, 44.

Medical Services, Incorporated (MSI) provides both basic medical transport and a paramedic service for a population of 228,000 spread over more than 3,000 square miles of central Lane County in Western Oregon. Five paramedic ambulances and three special back-up paramedic units are located at stations in the Eugene-Springfield area for 24-hour use. Six basic transport vehicles are provided on an as-needed basis. This paper describes the organization and finance of MSI, training, fleet maintenance, communications systems, and vehicles used. MSI maintains a vigorous public information and education programme. It has also established a mobile industrial health care service. Co-operation with fire and police departments and quick response groups is outlined.

DAY HOSPITALS

See Abstract Nos. 1365, 1394

INFECTIOUS DISEASES AND ISOLATION

See Abstract Nos. 1305, 1321

CHILDREN

See also Abstract No. 1326

1357. PAPADIA, J. La pediatria oggi: l'area delle cure primarie e l'ospedale pediatrico. **[Paediatrics today: primary care services and hospital paediatrics.]** *Ospedale*, Torino, 1979, March, vol. 32, no. 3, pp. 67-73.

The emphasis in paediatrics today is no longer solely on the diagnosis and cure of diseases of childhood but on: (i) the implementation of the laws relating to mother and child care; (ii) expansion of antenatal care; (iii) raising the standard of living and health education of the population; and (iv) increasing the quantity and quality of professional training in paediatrics. Primary care in paediatrics should focus on: (i) integration of prevention and care; (ii) the use of direct, individual, and collective means of information; (iii) development of health education; and (iv) the development

and co-ordination of the various services and structures. The paediatrician must have the support of an adequate number of health visitors. The author discusses the structure of a paediatric hospital and the concept of the day hospital. He suggests that a regional department of paediatrics be established to co-ordinate care, prevention, teaching, and research.

1358. LOUDON, I. S. L. **John Bunnell Davis and the Universal Dispensary for children.** *British Medical Journal*, London, 1979, May 5, vol. i, pp. 1191-1194.

The Universal Dispensary for Children was founded by John Bunnell Davis in 1816 and, after several changes of name, became the Royal Waterloo Hospital for Children and Women in 1903. It was the first institution in England devoted solely to the care of sick children. Davis opened several 'branches' by 1820 and moved the original dispensary to a larger building in Waterloo Bridge Road, but died four years later. By 1824 the annual total of new patients rose to 20,000, but procrastinating committees and financial difficulties prevented the admission of in-patients until 1856, when a bequest stipulated that there should be 16 beds, treating women as well as children. The Universal Dispensary for Sick Children played a major part in the foundation of children's hospitals in England and had its founder not died prematurely, would doubtless have been more successful.

1359. PINDING, M. Externer Pflegedienst—Ein Modell der Hauskrankenpflege bei Kindern. **[External care—a model of home care for sick children.]** *Bundesgesundheitsblatt*, Köln, 1979, April 12, vol. 22, no. 8, pp. 143-145.

Following a successful pilot experiment based on the children's hospital of the University of Berlin a more comprehensive experiment in the home care of children is to be carried out involving two paediatricians, two children's nurses and a specialist in social medicine. The pilot experiment involved the home care of 35 children, aged from one to 16, by a nurse from the hospital over a period of 12 months. The nurse had the backing of doctors, social workers, dietitians, remedial gymnasts and psychologists. Treatment by the general practitioners and out-patient visits were also involved. The main objectives were: shorter in-patient care to prevent harmful effects on the child; the support for parents of a qualified nurse; support for the general practitioner; and a reduction in costs resulting from shorter length of stay in hospital. Children selected for the pilot experiment were mostly those whose care in the home was made difficult by social conditions, but who needed general practitioner treatment and out-patient supervision rather than in-patient care.

1360. JANDER, E. Mobile Kinderkrankenpflege in Berlin. **[Mobile children's nurse in Berlin.]** *Deutsche Krankenpflegerzeitschrift*, Stuttgart, 1979, March, vol. 32, no. 3, pp. 149-151.

The author describes her work as mobile children's nurse attached to a Berlin hospital. Her main task is to look after children in their own homes after they have been discharged from the hospital. The Berlin newspaper financed the project for 12 months stipulated that priority should be given to the care of children who had suffered accidents. During the first six months 32 children were nursed at home: 20 of these had been discharged from hospital, seven were referred by general practitioners and five by the infant welfare service. This mobile nurse service relieves hospital nurses

and general practitioners. Doctors' instructions are carried out in the home under nursing supervision and the risk of hospital infection can be largely avoided.

GERIATRICS AND LONG-STAY

See also Abstract Nos. 1300, 1395

1361. GREEN, S. and others. **The collection of service utilisation data: a research note on validity.** *Social Science and Medicine*, Oxford, 1979, March, vol. 13A, no. 2, pp. 231-234.

This paper reports on a pilot study designed to measure the use of medical and personal social services provided for the elderly in Britain. Data were collected by interview from 93 people aged over 75 and were compared with the same data collected by record audit. The greatest correspondence between services reported in the interviews and those recorded in general practitioner and local authority records, tended to be regular and related to daily living, like meals on wheels and home help services. The results for contact with the doctor, the health visitor or the hospital were not so good. There was little agreement between recall and record on the drugs being taken. Studies aiming to answer questions on cost effectiveness are dependent upon respondent recall and in dealing with chronic care the focus is upon longer term cost implications. As recall over a long period may be difficult for the elderly, the author explains how the use of a health diary could assist recall and shorten interviews.

1362. DEPARTMENT OF HEALTH AND SOCIAL SECURITY. WORKING GROUP. **A programme for improving geriatric care in hospital: report.** (Chairman: Miss M. Heath). London, Department of Health and Social Security, 1978, [6]pp.

A working group was set up by the Department of Health and Social Security to prepare guidance and training aids to assist in the implementation of the recommendations of the report of the British Geriatrics Society and the Royal College of Nursing. The working group considered a programme of action and carried out a series of pilot studies in a limited number of districts to evaluate the development of a programme of action and if necessary to modify it. The report on the development by the pilot districts of a programme of action is outlined and various recommendations discussed.

1363. MILLER, D. B. **The maturation of long-term care.** *Journal of Long-Term Care Administration*, Washington, D.C., 1979, vol. 7, no. 1, pp. 1-23.

This paper reviews the literature of long-stay care to examine the different models of care in order to develop a rational plan for the future. Aspects covered are: clients/residents/patients; families; staff or paid caretakers; facilities or institutions; costs and financing; programmes and services; the community consumer; and types of long-stay care facilities. A list of 60 references to the literature is included.

1364. HEARN, C. R. **Staffing geriatric wards. Trials of a 'package'—2.** *Nursing Times*, London, 1979, May 3, vol. 75, no. 18, occasional papers, p. 52.

Nursing staff felt that although the 'package' system of geriatric care worked well during the trial period, the two weeks allowed did not give the ward time to adapt to

the new conditions. The other main comment concerned the apparent improvement in the patients' condition: they seemed more alert and aware of ward activities. The time spent on rehabilitation and emotional support increased during the trial, possibly because this type of care was assessed in the 'package' at an unreasonably high level. The time values used were satisfactory and the workload calculations were suitable for determining staff needs. However, a shortfall in direct care always occurred. The problem in developing a 'package' lies in prescribing a realistic standard of different types of care. If both needs and standards could be expressed within the care plans and related to expected outcome, an accurate deployment of resources could be achieved.

1365. WEISSERT, W. G. **Rationales for public health insurance coverage of geriatric day care: issues, options and impacts.** *Journal of Health Politics, Policy and Law*, Durham, N.C., 1979, vol. 3, no. 4, pp. 555-567.

America's long-term care system has been widely criticized for many short-comings. It has been said to rely too heavily upon institutional services; to cost too much; to force inappropriate levels of care upon patients; and to place an undue emphasis on the physical aspects of illness. Some of the alternatives are considered in this paper, particularly in relation to geriatric day care.

1366. WORLD HEALTH ORGANIZATION. REGIONAL OFFICE FOR EUROPE. **The organization and operation of long-term care services: report on a working group, Uppsala, 12-15 April 1977.** (ICP/HSD 013) Copenhagen, WHO Regional Office for Europe, 1978, [iii], 12pp.

This report considered the need for organizing long-term care and to recognize it as an essential feature of the total health care programme. The terms of reference were established and the organization and operation of long-term care services in the respective countries of the members of the Working Party described. Aspects considered included: the size and nature of the problem; the types of institutional service; relationship of institutional care vis à vis domiciliary care; preventive services; and co-ordination of medical and social services. Eleven recommendations are put forward. A list of participants is included.

CANCER

1367. SANTI, L., ESPOSITO, M. and TADDIA, C. Il nuovo istituto di oncologia di Genova. **[The new cancer institute at Genoa.]** *Tecnica Ospedaliera*, Milano, 1979, April, vol. 9, no. 4, pp. 20-30.

The new Oncology Institute in Genoa will be devoted to the prevention and cure of cancer, the rehabilitation of cancer patients, and research on the environment and occupational causes of cancer. It will co-operate with other health institutions in the region, integrating research with clinical applications, and will be the first Italian centre where the impact of the environment on carcinogenesis will be studied in depth. The Institute will have radiotherapy and nuclear medicine departments, out-patient clinics, a 20-bed day hospital, and 60 in-patient beds. An eight-storey block attached to the San Martino Hospital in Genoa will be ready for occupation by the end of 1979. Particular attention has been devoted to air conditioning and heat recovery systems

and, in addition to a diagram of the new building and four tables of cancer statistics, the article has a table showing the financial savings which will be achieved through the use of heat recovery.

NEUROLOGY AND NEUROSURGERY

1368. PAMPUS, I. Rehabilitation Hirnverletzter. Ein erfolgreich abgewickelter Gesamtplan an einem Beispiel aufgezeigt. **[Rehabilitation of brain-injured patients—demonstrated with the help of a successfully performed individual rehabilitation plan.]** *Rehabilitation*, Stuttgart, 1979, May, vol. 18, no. 2, pp. 51-55.

Under West German legislation an individual rehabilitation plan has to be set up if several measures (medical, vocational and social, for example) are involved or if different agencies share financial responsibility. This usually applies in the case of rehabilitation after brain injury. A detailed account demonstrates how co-operation between hospital, rehabilitation centre, doctor, rehabilitation agency and employer leads to overall improvement in the rehabilitation of a 17-year-old boy with severe brain injury. Such patients require comprehensive and long-term treatment.

CARDIOLOGY

See Abstract Nos. 1262, 1324

UROLOGY

1369. DALL'ACQUA, G. F., ROMEO, C. and VERCELLINO, L. Tipologia dei centri di emodialisi e loro caratteristiche igienico costruttive. **[Design of haemodialysis centres and hygiene aspects.]** *Ospedale*, Torino, 1979, March, vol. 32, no. 3, pp. 75-82.

The authors describe the accommodation required for an in-hospital dialysis centre and an independent dialysis centre. The former will require separate dialysis rooms for: (i) patients with chronic uraemia; (ii) patients with contagious diseases; (iii) acute or complicated cases; (iv) training new patients; and, in addition, laboratories, waiting rooms, and service areas. The accommodation for the independent centre will naturally be less extensive especially if service is on a limited-assistance or self-service basis. The authors examine the problem of the disposal of waste from the centre and in particular the disposal of soiled plastic material. Autoclaving of the latter at 120°C is recommended, since this compacts the material as well as sterilizing it. They also suggest that all the dialysis centres and in-hospital units could be linked by computer. Ground plans of a proposed new in-hospital dialysis centre and an extra-hospital centre, both in Turin, are included.

VENEREAL DISEASE

1370. PARTON, C. W. and SGROI, S. M. **An alternative to the problem of insufficient physician manpower in the clinical care of sexually transmitted diseases.** *British Journal of Venereal Diseases*, London, 1979, April, vol. 55, no. 2, pp. 144-146.

The reasons for the shortage of physicians working in the treatment of sexually transmitted diseases in the United States are outlined. After surveying the needs,

available resources and financial mechanisms, the Department of Ambulatory and Community Medicine, Mount Sinai Hospital, Hartford, Conn., developed a programme to meet the problem. This involved: (i) preparation of appropriate management protocols by age, sex and special need; (ii) development of pools of nurse practitioners, physician associates, and physicians, who rotate through various assignments, no one of which would necessarily be stimulating on a permanent basis but which together provide a varied and exciting medical challenge; (iii) arrangement of training courses; and (iv) physician supervision of clinics in person or by telephone.

SURGERY

1371. FROST, C. E. B. and FRANCIS, B. J. **Clinical decision-making: a study of general surgery within Trent RHA.** *Social Science and Medicine*, Oxford, 1979, March, vol. 13A, no. 2, pp. 193-198.

A theory of consultant behaviour when deciding whether to admit a patient is described and used to formulate three hypotheses on the relationship between the resources available and the demand for in-patient care. Data on the use of general surgical beds within the Trent Regional Health Authority were used to test the hypotheses, and the statistical calculations are described. It was found that it was the provision of hospital beds rather than the size of a district or the number of consultants which affected demand. In fact, a one per cent increase in the number of consultants per 1,000 population would probably result in a one per cent increase in waiting lists. This study of consultant behaviour showed that waiting lists cannot be shortened by simply increasing the number of beds available. However, of the allocation of resources within a region partly depended upon keeping lists within prescribed limits, attempts to reduce patient waiting time might be more successful.

1372. LOGERFO, J. P. and others. **Rates of surgical care in prepaid group practices and the independent setting. What are the reasons for the differences?** *Medical Care*, Philadelphia, 1979, Jan., vol. 17, no. 1, pp. 1-10.

As part of a larger comparative study of a prepaid group practice (PGP) and an independent practice plan in which physicians were paid on a fee-for-service basis (IPP), the patterns of surgical care for hysterectomy, cholecystectomy, appendectomy and tonsillectomy/adenoidectomy were assessed. Overall, there were 215 such procedures with an exposure adjusted rate five times higher in the IPP than in the PGP. After eliminating 43 per cent of procedures in the IPP and 22 per cent in the PGP which did not meet criteria for either necessary, appropriate or justifiable surgery, the exposure adjusted rate differential was 3.9 times higher in the IPP, with the differences in the rates being mainly attributable to hysterectomy and tonsillectomy/adenoidectomy. It is concluded that there were more unnecessary procedures in the IPP, but the fact that a significant difference in the incidence of surgery persisted even after elimination of such cases suggests that the differences in rates of surgery between the IPP and PGP cannot be solely attributed to a higher rate of inappropriate surgery in the IPP.

1373. URICH, D. J. **Out patient surgery center: a financial forecast of the first year of operation.** Ann Arbor, Mich., and London, University Microfilms International, 1976, [vii], 112pp.

This thesis, submitted in 1976, is a study of Bethesda Hospital, Maryland. An

initial review is made of the existing literature followed by a detailed study of the likely demand for out-patient surgery. Staffing levels are considered and the penultimate chapter deals with costs and charges to patients. The final chapter concludes that there is a case for an out-patient surgery centre and that despite the charges it will be heavily used. The book, also available on microfilm, is one of a series of hospital management studies.

MATERNITY

1374. SHAPLAND, D. E. **Extended role for general practitioners in obstetrics? A medical audit.** *British Medical Journal*, London, 1979, May 5, vol. i, pp. 1119-1200.

A study was carried out to evaluate provision of services, process of medical care and outcome in general practitioner obstetric units in Berwick, Whitby, Guernsey and Brecon. Details of facilities are described for each unit, but all were equipped to induce labour, perform instrumental deliveries and remove placentas manually. All had some foetal monitoring equipment, but Caesarean sections could be performed at only two of the units. Proportions of normal deliveries during 1976 and 1977 varied from 75 per cent to 93 per cent. Perinatal mortality and transfer rates for both neonates and mothers were acceptably low. With specialist help in broadening the local doctors' experience of abnormal labour, general practitioner units should be able to provide an excellent obstetric service.

PSYCHIATRY

See also Abstract Nos. 1320, 1325

1375. GLASER, E. M. and BACKER, T. E. **Organization development in mental health services.** *Administration in Mental Health*, New York, 1979, vol. 6, no. 3, pp. 195-215.

Organization development, widely used in industry to improve communications, is now being introduced into mental health organizations. The technique may be useful in institutions which have to meet changes in legal requirements, peer reviews and increased union activity by staff. Differences between private industry and mental health organizations necessitate the adaption of organization development to suit this type of public body. Its advantages include an increased capacity to manage organizational change and a greater sharing of responsibility among administrators. On the other hand, organization development tends to be expensive and sometimes places emphasis on human communication at the expense of technological advances. It is not a panacea for all problems faced by mental health institutions, but a background knowledge of organization development is a useful addition to any course in mental health administration.

1376. WERNERT, T. M. **Planning for mental health services.** *Administration in Mental Health*, New York, 1979, vol. 6, no. 3, pp. 216-224.

This article discusses a model which was used to collect and analyze data in the planning of mental health services in Ohio; this plan has now been submitted for public review and comment. The planning model contained five components: (i) present

demand; (ii) determination of groups at risk; (iii) possible future needs; (iv) influence of outside issues; and (v) development of priorities. The collection procedure and sources of data are described in detail. There were some gaps in available data, notably the mental health services provided by private practitioners and private agencies. The author suggests that the planning effort should be well publicized, should include a broad representation of service providers and the plan must be supported by reliable data.

1377. RUBIN, J. **Economics, mental health and the law.** Lexington, Mass., D.C. Heath, 1978, xx, 178pp. £11.50

This study of the economics of the mental health system in the United States examines the fundamental economic rationales underlying public provision of mental health care. The chapters cover: economics, law and the mentally disabled; the costs of mental disability; the structure of the mental health care system; the mentally disabled and the courts; the economic implications of the right to treatment; the economic implications of the least restrictive alternative doctrine; social justice and the mentally disabled; and the role of litigation in social policy for the mentally disabled. Tables and figures are included.

1378. LEOPOLDT, H. **Community psychiatric nursing—1.** *Nursing Times*, London, 1979, May 17, vol. 75, no. 20, occasional papers; pp. 53-56.

The relationship between psychiatric hospitals and the community in the development of community psychiatric nursing is outlined. Over the past 20 years psychiatric hospitals have reduced their in-patient population considerably. At Littlemore Hospital, Oxford, the reduction was from 1,000 to 300. Immediate causes of this trend include: (i) effective neuroleptic drugs; (ii) the development of environmental treatment; and (iii) a re-assessment of the function of the psychiatric hospital. In addition, community psychiatric nurses now have a formal qualification (CPN) and have formed an association. The background of hospital experience combined with knowledge obtained on a course, makes the CPN a valuable addition to the therapeutic community team. The majority are hospital-based, but some are employed by the community nursing division and are attached to health centres. The work of the CPN's based at Littlemore Hospital centres on: (i) a rehabilitation service; (ii) a group home scheme; and (iii) care of the elderly mentally infirm in the community. The majority of domiciliary visits arise from referrals within the hospital, but a general practitioner attachment scheme has been operating since 1972.

1379. CATHCART, H. R. **Issues facing American hospitals.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, March, vol. 30, no. 3, pp. 193-194.

The most critical problem facing American hospitals today is how to control rising costs. Although psychiatric medicine is not a major contributor to inflation, psychiatric services are unlikely to escape public regulation of health care spending if it is implemented. In 1978 three of America's largest associations for health care launched a cost containment programme which has achieved some success. Many hospital costs result from the efforts of the hospital to comply with the increasing number of regulations

imposed by federal and state agencies and others. Financing of hospital-based post-graduate medical education is also at risk. How hospitals can be organized to make the best use of their many resources at reasonable cost is the great challenge facing hospital officials in the 1980s and beyond.

1380. FLAMM, G. H. **The expanding roles of general-hospital psychiatry.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, March, vol. 30, no. 3, pp. 190-192.

The numbers of psychiatric units in general hospitals have been expanding rapidly in the United States in recent years. General hospital psychiatry offers many opportunities for medical students to see the relationship between psychiatry and medical and surgical illness and the impact of mental illness on families. Community and general hospitals are increasingly supplying the first year of basic psychiatric residency. Educational opportunities are also available for nurses, social workers and other staff, and the general hospital provides an ideal setting for research studies. The general hospital unit plays a valuable part in bringing psychiatry back into the mainstream of hospital medicine. Some factors which hinder their optimal use are discussed. These include: (i) financing; (ii) regulatory controls; and (iii) regional variations in length of stay for the same diagnoses. The general hospital psychiatrist must also play a part in looking after people in other types of care, as well as giving psychiatric help to those already in hospital.

1381. GREENHILL, M. H. **Psychiatric units in general hospitals: 1979.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, March, vol. 30, no. 3, pp. 169-182.

Despite the emergence of community mental health centres, the general hospital has become the focal point for the delivery of psychiatric care in the United States. The author reviews the position of the psychiatric unit in the general hospital, including its history from the 1930s to the present day, its economic position and its relation to the rest of the hospital. The average unit contains 25 to 35 beds and keeps patients for an average 11 days. In general, it aims to provide acute treatment, prevention of chronic conditions and a speedy return of the patient to the community. There is little attempt to serve chronic patients. The units seldom accept patients transferred from elsewhere in the hospital and the part they play in the community mental health service is undefined. The author maintains that the units could be improved by ending the competition for the shortest stay and planning for two types of unit for each hospital, one for medical and surgical patients needing psychiatric help and one for patients with acute psychiatric problems.

1382. SANDERS, C. A. **Reflections on psychiatry in the general-hospital setting.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, March, vol. 30, no. 3, pp. 185-189.

For psychiatry to be integrated successfully into the general hospital, the psychiatrist must function within the medical structure of the hospital, whether as a primary physician or as a specialist consultant. Psychiatric services should be available to all patients through a consultation-liaison system and the financing of such a system must be carefully worked out. It is important that psychiatric education is not geared only towards the psychiatrist's role as a primary physician. Likewise, medical students should

be introduced to psychiatry even if they intend to specialize in other fields. The future of the general hospital and that of psychiatry within the general hospital setting cannot be separated.

1383. VIENBERG, B. Distriktspsykiatrisk forsøg ved Aalborg Psykiatriske Sygehus, afsnit S: mulighed for tidligere kontakt med patienten i dennes hjemmemiljø. **[A district psychiatric experiment by Aalborg Psychiatric Hospital, sector S: possibility of earlier contact with patients in their home environment.]** *Sygeplejersken*, København, 1979, April 4, no. 14, pp. 4-7.

The aim of establishing a district psychiatric project in 1974 involving the two municipalities of Hals and Aabybro was to act early, and if possible preventively, in the course of the psychiatric patient's illness. The hospital was opened in 1970 and has 256 beds for acute adult psychiatric cases and 20 childrens' beds. In recent years more stress has been laid on group and environmental therapeutic methods. Experience gained during home visits and conversations prior to committal had shown that patients were frequently more confident and relaxed on admission, and did not always need hospital treatment; so the project, of one year's duration, was commenced in June 1978. The project is designed to gain further experience of treatment in the patient's own environment; to assess the effects of this action on, for example, frequency of committal, use of resources, etc.; and to extend inter-professional co-operation outside the hospital. Each municipality is visited by a team consisting of a doctor, a psychiatric district nurse, a social affairs adviser and a nurse, at least one day a week. A report is expected in October 1979.

1384. ALLDERIDGE, P. **Hospitals, madhouses and asylums: cycles in the care of the insane.** *British Journal of Psychiatry*, London, 1979, April, vol. 134, pp. 321-334.

The author outlines the history of the institutional care of the mentally disordered, believing that there are few ideas on the subject which have not existed before in some previous age. There is evidence to suggest that in the mediaeval period the insane were treated alongside other categories of the sick. However, the Bethlem Hospital in Bishopsgate was concerned exclusively with the care of the insane by the end of the sixteenth century, being extended about 1630 and 1674. The Poor Law of 1601 increased the responsibility of the Justices of the Peace for the care of lunatics and the first statute providing for the confinement of the dangerously insane is contained in the Vagrancy Act of 1714. An insane man was generally held in a house of correction. By the end of the eighteenth century public subscription hospitals for the care of the insane were established in several provincial cities. Pauper lunatics were commonly placed in private madhouses, upon which certain controls were placed by an act of 1774 and the Lunacy Act of 1890. County asylums were built as a result of an act of 1845 and many are still psychiatric hospitals today. Little further progress was made in the treatment of mental disorder until the Mental Health Act of 1959.

1385. RIEKE, M. Die Notwendigkeit einer fachlichen Weiterbildung für das Pflegepersonal in der Psychiatrie, begründet im Wandel innerhalb dieser Disziplin. **[The need for specialist post-basic training of psychiatric nurses based on the changes in this discipline.]** *Deutsche Krankenpflegezeitschrift*, Stuttgart, 1979, April, vol. 32, no. 4, pp. 181-189.

The nursing care of psychiatric patients requires knowledge and experience of many

subjects not covered by basic nursing training. These include psychology and social sciences, knowledge of psychiatric medicine, and the influence of family and community conditions on the genesis and course of psychiatric illness. The psychiatric nurse must also be able to distinguish between experience and behaviour resulting from disease, personality or social circumstances. The paper goes on to describe the various aspects of psychiatric nursing under the following heads: the patient's situation; changes in the role of the patient; changes in the role of the nurse; basic therapeutics; the ward as a therapeutic environment; group work with the patient; the therapeutic team; areas of psychiatric nursing (including open and closed wards, psychotherapy, day and night hospitals, halfway homes, etc.); and out-patient services.

1386. FREEMAN, H., CHEADLE, A. J. and KORER, J. R. **Use of hospital services by chronic schizophrenics in the community.** *British Journal of Psychiatry*, London, 1979, April, vol. 134, pp. 417-421.

A sample of chronic schizophrenic patients living in the community in Salford were re-assessed using the Present State Examination one year after a previous interview. During this time their use of psychiatric hospital services was recorded. A group of 102 patients had adequate interviews on both occasions and these patients could be divided into eight heavy users of services, 14 medium users and 63 light users. 17 only saw their general practitioners or had no treatment. There was little correlation between severity of clinical condition and use of services and the second examination scores were not significantly different from the first. Heavy and medium users of the hospital services were also more frequently in contact with the social services. Thus, the control of overt schizophrenia is a relatively economic exercise, provided that an integrated system of mental health services exists.

1387. CONFEDERATION OF HEALTH SERVICE EMPLOYEES. **NHS secure treatment units: a policy statement; report of a special working party offering information, advice and guidance to COHSE members.** Banstead, COHSE, 1979, [iv], 17pp. £0.50

In 1975 the Confederation of Health Service Employees (COHSE) set up a working party to examine the problems faced by staff dealing with violent patients in the course of their work. This is a second report by the working party (see also Hospital Abstracts vol. 18, no. 86) and is intended as a blueprint for members involved in the setting up and subsequent staffing of special units. COHSE hope to encourage the setting up of more permanent and interim units which Health Authorities have so far been slow to provide, despite DHSS grants. Financial arrangements are discussed and a table is given showing progress to December 1978. There are chapters on: siting and design; types of patients; and staffing.

1388. FREEMAN, H., CHEADLE, A. J. and KORER, J. R. **A method for monitoring the treatment of schizophrenics in the community.** *British Journal of Psychiatry*, London, 1979, April, vol. 134, pp. 412-416.

A research project was undertaken in Salford to evaluate a system for monitoring the progress of 95 schizophrenics who were receiving treatment outside the hospital. Monitoring began by finding out where the patient received treatment and a 'treatment board' with coloured signals recorded when visits were due and when treatment had

been received. Admissions to hospital were traced by means of the Salford Psychiatric Case Register. Thus it was possible to record what treatment the patient should be receiving and then monitor its application. It was also necessary to find out treatment information about patients who were not receiving treatment at the beginning of the study, or who had been re-admitted and subsequently discharged from hospital. The treatment board helped those involved with care to get a clearer picture of the overall treatment programme. The system is inexpensive to operate and could be of value for a number of chronic disorders.

1389. GHODSE, A. H. **Recommendations by accident and emergency staff about drug-overdose patients.** *Social Science and Medicine*, Oxford, 1979, March, vol. 13A, no. 2, pp. 169-173.

Doctors and nurses working in London accident and emergency departments were asked in a questionnaire survey for their recommendations about the management of drug-dependent overdose and self-poisoning patients. There was general agreement that patients taking overdoses should not be discharged without full psychiatric evaluation and that a resident psychiatrist should be available to advise them. A majority of respondents agreed there should be a full-time security officer on duty in accident and emergency departments and thought that additional training was necessary to deal with aggressive patients. Seventy-nine per cent felt that drug dependent patients should be taken to special emergency centres. About 60 per cent of respondents supported the idea of a voluntary ban on the prescription of barbiturates. Details are given where the opinions of doctors and nurses on certain questions differed significantly.

1390. SUMMERS, F. **Characteristics of new patient admissions to aftercare.** *Hospital & Community Psychiatry*, Washington, D.C., 1979, March, vol. 30, no. 3, pp. 199-202.

Consecutive new admissions to the after-care clinic at Northwestern Memorial Hospital, Chicago, were surveyed over a nine-month period with regard to demographic characteristics, symptoms, diagnoses and social and domestic activities. Just over half the patients were males with an average age of 34.7 years. A high percentage were unemployed and socially isolated. Sixty-two per cent of the sample were schizophrenic and 78 per cent had some form of psychosis, but anxiety and depression were the most common presenting problems. Most of the patients had been in hospital numerous times and their problems derived more from their empty lives than from psychotic symptoms. After-care clinics, although designed for discharged chronic psychiatric patients, are often unable to meet their needs. The author questions the wisdom of continually discharging patients who will be re-admitted and suggests that criteria for discharge should include the capacity for social adjustment.

1391. ASTON, G. and WHEATLEY, M. **Building up the foundation of rehabilitation.** *Health and Social Service Journal*, London, 1979, May 18, vol. 89, no. 4642, pp. 606-607.

Epsom and Ewell was faced with the problem of accommodating discharged patients from its five psychiatric hospitals, most of whom wished to remain in the area. Several years ago, a housing association established a group home in the form of a hostel which houses 12 people and it hoped to set up a second. The borough council then leased a house to the local health authority and social workers and nursing staff began to select

potential occupants and prepare them for living in a group home. Support for the residents is provided by a community psychiatric nurse and a hospital social worker; the residents, all with local jobs, are responsible for paying the rent. The group home has been operating for a year and appears to be a success. The residents have adapted well and may be considered for council accommodation in their own right.

1392. PHILIP, A. E. **Prediction of successful rehabilitation by nurse rating scale.** *British Journal of Psychiatry*, London, 1979, April, vol. 134, pp. 422-426.

In the rehabilitation of the long-stay psychiatric patient the part played by nurses is crucial. The Nurses' Observation Scale for In-patient Evaluation (NOSIE), a ward behaviour rating scale, was used in the assessment of a group of long-stay patients at Bangour Village Hospital. After a follow-up period of three years, it was found that the NOSIE scales had differentiated correctly between continuing in-patients and those discharged. The use of regression analysis showed that the most important variables in a predictive differentiation are age and degree of psychosis. NOSIE does not make excessive demands on ward time and, while other factors need to be considered, has a predictive as well as a monitoring value in the assessment of long-stay patients.

1393. BRODSKY, C. and PLATT, R. T. **The rehabilitation environment.** Lexington, Mass., Lexington Books, 1978, xvi, 158pp. £11.00

When a psychiatric unit at the University of California School of Medicine was converted to a rehabilitation unit a methodical study of the new unit was undertaken. Observations of daily and special events were made, contact with key staff was maintained and both patients and staff were interviewed. Problems between staff and patients observed in the old unit reappeared, costs escalated and after less than five years the unit closed. Some conclusions are drawn about the reasons for the difficulties, the planning is described and a description is given of the day-to-day life in the unit.

1394. TYRER, P. J. and REMINGTON, M. **Controlled comparison of day-hospital and outpatient treatment for neurotic disorders.** *Lancet*, London, 1979, May 12, vol. i, pp. 1014-1016.

A group of 106 patients with anxiety phobic and depressive neuroses who attended the out-patient clinics of six psychiatrists were randomly allocated to out-patient care or to two forms of psychiatric day care. Ratings of symptoms and social adjustment were recorded before treatment, at four months, and at eight months in 89 of the patients. There were no important differences in the outcome of day care and out-patient treatment but the patients were more satisfied with the out-patient service with regard to consistency of treatment and staff understanding. Day hospital care is suitable as a short term measure for neurotic patients, but not for long term care as out-patient care is more economical both in time and staff. Psychiatric day hospital services should concentrate on the treatment of personality disorders and the rehabilitation and after-care of psychotic patients.

1395. WHITEHEAD, T. **A service for the elderly mentally ill in Brighton.** (KFC/79/792) Brighton, Bevendean Hospital and King Edward's Hospital Fund for London, 1979, 121pp. £1.50

A service for the elderly mentally ill was started at St. Francis Hospital, Haywards

Heath in 1967 and since that time there have been considerable developments in the field of 'psychogeriatrics'. This book deals with the services in the Brighton and Hove area, particularly Bevendean Hospital and Brighton General Hospital. There are chapters by many different authors aimed at all those concerned in this field including: nurses; occupational therapists; social workers; medical secretaries and the medical staff. Several of the chapters consist of reprints of journal articles.

1396. BAVIN, J. **Why the recommendations will not succeed. Jay Report critique—1.** *Nursing Times*, London, 1979, May 17, vol. 75, no. 20, pp. 821-825.

The Jay Committee report (1979) on the care of the severely disturbed and handicapped itself confesses to dissension among committee members. The report's model of residential care may seem ideal, but the two main difficulties are the recruitment and training of suitable staff. The author questions three premises in the report, namely that: (i) all recent developments in work with the severely handicapped have failed; (ii) all mentally handicapped people should share the same needs and rights; and (iii) special services tend to separate the mentally handicapped from others. Not all the mentally handicapped benefit from good residential care and the skills needed by staff in hospitals for the handicapped show what a high degree of specialized training is required. Valuable developments have been made in the training of community nurses in mental handicap, but there is as yet no adequate course for residential care workers in this field. The author believes that the report underestimates: (i) the training required; (ii) the necessary ratio of staff to residents; and (iii) the cost of the proposed scheme.

1397. FELCE, D. and MANSELL, J. **Checklist for planning a residential unit for severely and profoundly mentally handicapped people.** (Research Report No. 147) Winchester, Health Care Evaluation Research Team, 1979, [ii], 34pp.

This checklist specifies the essential details of the operational policy of a residential unit for severely and profoundly mentally handicapped people. The items are derived from the specification of operational policy of the Wessex locally based hospital unit.

1398. DEPARTMENT OF HEALTH AND SOCIAL SECURITY, SCOTTISH HOME AND HEALTH DEPARTMENT AND WELSH OFFICE. COMMITTEE OF ENQUIRY INTO MENTAL HANDICAP NURSING AND CARE. **Report.** (Chairman: Peggy Jay). (Cmnd. 7468-I, II) London, Her Majesty's Stationery Office, 1979, 2 vols. £7.00

This report into mental handicap nursing and care under the National Health Service is in two volumes. The first volume considers developments in mental handicap care and the second presents the results of a survey of nurses and residential care staff carried out by the Office of Population Censuses and Surveys on behalf of the Committee of Enquiry. Aspects considered in the first volume include: (i) introduction and background to the enquiry and scope of the report; (ii) written and oral evidence; (iii) philosophy and model of care; (iv) manpower; (v) staff training; (vi) organization and management; (vii) finance and priorities; and (viii) conclusion and recommendations. A glossary of terms (pp. 180-181) and a list of references in the report (pp. 182-184) are also included.

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Building Design Partnership, Vernon Street, Preston, Lancashire, England.
Confederation of Health Service Employees, Glen House, High St., Banstead, Surrey, England.
Dansk Sygehus Institut, Landemaeker 10, DK-1119 København K, Denmark.
Department of Health and Social Security, Alexander Fleming House, Elephant & Castle, London SE1 6BY.
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